Health Services
LOS ANGELES COUNTY

March 20, 2007

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

To improve health through leadership, service and education.

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The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL OF SOLE-SOURCE CLAIMS ADJUDICATION SERVICES AGREEMENT WITH AMERICAN INSURANCE ADMINISTRATORS, A SUBSIDIARY OF MANAGEMENT APPLIED PROGRAMMING, INC.
(All Districts) (3 Votes)

IT IS RECOMMENDED THAT YOUR BOARD:

Approve and instruct the Director of Health Services,or his designee, to sign a sole-source Agreement, substantially similar to Exhibit I, with American Insurance Administrators (AIA), a fully owned subsidiary of Management Applied Programming, Inc., to continue as the County's contracted medical claims adjudicator for services provided by non-County physicians to County responsible patients, effective upon Board approval through March 31, 2008, with a maximum obligation of $2.2 million, with provision for four twelve-month automatic renewals through March 31, 2012 for an additional $9.0 million, for a total maximum obligation of $11.2 million; partially offset by up to $5.7 million in State allocated Tobacco Tax and SB 612 administrative funds resulting in a net County cost of $5.5 million.

PURPOSE/JUSTIFICATION OF THE RECOMMENDED ACTION:

Approval of the recommended sole-source Agreement with AIA will allow for the continued use of a uniquely qualified vendor to process thousands of non-County physician claims annually for County responsible patients in programs such as the Physician Services for Indigents Program (PSIP), the Public-Private Partnership (PPP) Program and the new MetroCare model and its concomitant urgent development and processing requirements. The current Agreement with AIA is scheduled to expire on June 30, 2007.

Since approval of their initial agreement, after a competitive-bid process nearly ten years ago, AIA has created a customized, reliable, efficient, and effective claims processing and data reporting system specifically tailored to meet the needs of the Department of Health Services ("Department"). This

contractor has an exceptional understanding of the County PSIP and PPP Programs' architecture and ideology and has developed customized programming, software, communications, disaster recovery and security maintenance. Additionally, it has a history of consistently and quickly responding to the changing needs and demands of the Department through innovation and a partnership approach.

In fact, due to this relationship and AIS's technical capabilities and thorough understanding of County programs related to non-County physician providers, they have offered to develop and provide under this Agreement, at no additional cost to the County; data conversion and electronic file transfer functionality for non-County hospital claims data required to meet State Medically Indigent Care Reporting System (MICRS) and California Healthcare for Indigents Program (CHIP) reporting requirements.

The PSIP and PPP programs are very large (a combined total of about one million claims annually), complex, and multifaceted, requiring significant knowledge and understanding of County and provider organization operations and interaction with thousands of non-County physicians, clinics, and billing offices. Contracting with another vendor(s) would generate software development costs to replicate the current customization, disrupt access to and require conversion of more than nine million PSIP and PPP claims records, impact over 4,000 non-County physicians, and perhaps most importantly delay initiation of claims processing and reporting functionality for MetroCare.

Due to AIA's familiarity with non-County Physician claims processing and reporting for the County, and its experience and expertise in customizing such systems for the County, no other vendor could initiate non-County physician claims processing for MetroCare with the same rapidity and effectiveness as AIA. An unnecessary delay in initiating claims processing services for MetroCare could result in non-County physicians refusing to participate in the program and jeopardize provision of timely and needed care to these patients.

Transitioning to a new contractor would be further complicated because final processing of claims for a fiscal year can continue for up to two years beyond the end of that fiscal year due to the appeals process and program auditing. This presents a risk of delayed processing and payment of claims to non-County physicians and non-profit providers of PPP services which rely on timely receipt of payments. Any such delay could result in reduced physician on-call emergency room panels and jeopardize the fragile emergency and trauma care systems.

The County-developed Physician Reimbursement Advisory Committee (PRAC) strongly endorses the recommended Agreement with AIA and expressed significant concern about the potential detriment to PSIP should a vendor change be made.

The PRAC is comprised primarily of physicians representing organizations such as the Los Angeles County Medical Association (LACMA), California Chapter of the American College of Emergency Room Physicians, and the County's Trauma Hospital Advisory Committee, the

Hospital Association of Southern California (HASC) and billing agencies, along with Department representatives.

FISCAL IMPACT/FINANCING:

For the first year of the contract, AIA will process and adjudicate all PSIP and MetroCare manual (hard-copy) and electronic claims at $2.85 and $1.50 each, respectively, which are the same rates that have been in place for PSIP claims since October 2002. The negotiated processing and adjudication rates for each year of the Agreement are as follows:

	Manual	Electronic
Year 1	$2.85	$1.50
Year 2	$3.00	$1.60
Year 3	$3.00	$1.60
Year 4	$3.15	$1.65
Year 5	$3.15	$1.65

AIA will continue to process and adjudicate PPP claims at the current Fiscal Year (FY) 2006-07 rates, and provide Medi-Cal matching identification services at the current rate of $2,000 per month for PSIP, which have been in use since October 2002, during the full duration of the agreement including any and all automatic renewals. In addition, AIA will provide Medi-Cal matching identification services at the reduced rate of $1,000 per month for MetroCare claims.

Funding is included in Health Services Administration's (HSA) FY 2006-07 Final Budget, will be requested in HSA's FY 2007-08 Final Changes Budget Request, and will be requested in future fiscal years.

The maximum obligation for this Agreement upon Board approval through March 31, 2008 is $2.2 million offset by up to $1.1 million in State allocated Tobacco Tax and SB 612 administrative funds (for the PSIP and MetroCare services components), and $1.1 million in net County cost for the PPP Program.

The total maximum obligation for the four additional twelve-month automatic renewals is $9.0 million offset by up to $4.6 million in State allocated Tobacco Tax and SB 612 administrative funds (for the PSIP and MetroCare services component), and $4.4 million in net County costs for the PPP Program.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS:

The Department is responsible for processing claims for payment to non-County physician providers who, through the PSIP, bill the County for services provided to eligible indigent persons in non-County facilities. In 1990, the Board approved an agreement with an external

adjudication vendor to provide AB 75 (i.e., Proposition 99 Tobacco Tax Initiative) claims processing for DHS. In December 1991, this Agreement was extended to include the EMS Maddy Fund (SB 612) claims processing services. In 1993, and again in 1997, a Request for Proposals was released and AIA was selected as the contractor to provide the processing services for all non-County physician claims.

In addition, DHS adjudicates claims for payment to PPP Program contractors providing medical services to indigent patients throughout the County. The PPP Program began under DHS' Medicaid Demonstration Project (1115 Waiver) in 1996. In April 1997, the PPP Program solicited proposals from various prospective vendors, and AIA was selected to provide claims adjudication services for the PPP Program. AIA has continued to provide such services since September 1997.

On September 30, 1997, the Board approved Agreement No. 71048 with AIA to provide medical claims processing services for various programs, including PSIP, PPP Program, and General Relief (GR) Programs. Subsequently, the Board approved Amendment Nos. 1 through 3, to extend the term, increase the maximum obligation, and expand services.

On May 31, 2005, the Board approved Agreement No. 702081 with AIA to allow for continued provision of medical claims adjudication services for the PSIP and PPP Programs effective July 1, 2005 through June 30, 2006 with delegated authority to the Director of DHS to extend the term for an additional 12 months. On July 10, 2006, upon written mutual consent, as provided in the Agreement, the Agreement was extended for an additional 12 months through June 30, 2007.

The sole-source Agreement may be terminated for convenience upon a 30-days advance written notice by either party.

County Counsel has reviewed and approved the sole-source Agreement, Exhibit I, as to use and form.

Attachment A provides additional information.

CONTRACTING PROCESS:

The rates, terms, and conditions included in the recommended Agreement resulted from negotiations between the Department and AIA. Information concerning sole-source agreements is not advertised as a contract business opportunity on the Los Angeles County Online Web Site.

IMPACT ON CURRENT SERVICES (OR PROJECTS):

Approval of this Agreement will allow the Department to continue, without disruption or delay, medical claims processing and adjudication services for the PSIP and PPP programs and expedite provision of these services for the new MetroCare indigent services program.

When approved, the Department requires three signed copies of the Board's action.

Respectfully submitted,

Bruce A. Chernof, M.D.
Director and Chief Medical Officer

BAC:lvb
AIA Board Ltr.lvb.wpd

Attachments (2)

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

ATTACHMENT A

SUMMARY OF AGREEMENT

1. Type of Service:

   Adjudication of medical claims for indigent patients under the Physician Services for Indigents Program, Public-Private Partnership Program and MetroCare.

2. Agency Address and Contact Person:

   American Insurance Administrators (AIA)
   13191 Crossroads Parkway North, Suite 205
   City of Industry, California 91746
   Contact Persons: Furrokh Dastur, President or
   Manaz Billimoria, Assistant Vice President
   Telephone: (562) 908-4567/Facsimile (562) 695-6105

3. Term:

   The sole-source Agreement with AIA is effective upon Board approval through March 31, 2008, with provision for four twelve-month automatic renewals through March 31, 2012.

4. Financial Information:

   The total maximum obligation is $11.2 million, consisting of 2.2 million effective upon Board approval through March 31, 2008, and 9.0 million for the four twelve-month automatic renewals through March 31, 2012, partially offset by up to $5.7 million in State allocated Tobacco Tax and SB 612 administrative funds resulting in a net County cost of $5.5 million.

   Funding is included in Health Services Administration's (HSA) FY 2006-07 Final Budget, will be requested in HSA's FY 2007-08 Final Changes Budget Request, and will be requested in future fiscal years.

5. GEOGRAPHIC AREA TO BE SERVED:

   Countywide.

6. RESPONSIBLE FOR PROGRAM MONITORING:

   Fiscal Services Chief and the Office of Ambulatory Care.

7. APPROVALS:

Office of Ambulatory Care:	Wesley Ford, Director
Emergency Medical Services Agency	Carol Meyer, Director
Fiscal Services:	Mark Corbet, Chief
Contracts & Grants:	Cara O'Neill, Chief
County Counsel (as to form):	Sharon A. Reichman, Principal Deputy

EXHIBIT I

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

CLAIMS ADJUDICATION SERVICES AGREEMENT

WITH

AMERICAN INSURANCE ADMINISTRATORS (AIA)
A SUBSIDIARY OF MANAGEMENT APPLIED PROGRAMMING, INC.

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
CLAIMS ADJUDICATION SERVICES AGREEMENT

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

EXHIBITS AND ATTACHMENTS

Contract # _____

CLAIMS ADJUDICATION SERVICES AGREEMENT

THIS AGREEMENT is made and entered into this _____ day of _____, 2007,

by and between COUNTY OF LOS ANGELES (hereafter "County"),

and AMERICAN INSURANCE ADMINISTRATORS ("AIA"), A SUBSIDIARY OF MANAGEMENT APPLIED PROGRAMMING, INC. (hereafter "Contractor").

WHEREAS, pursuant to the provisions of the State of California Welfare and Institutions Code ("WIC") section 16950 et seq., and Health and Safety Code ("HSC") section 1797.98a et seq., County has established and maintains a Physician Services for Indigents Program (hereinafter referred to as "PSIP") and a Public Private/Partnership Program (hereinafter referred to as "PPP Program"), and a MetroCare Physician Program (hereinafter referred to as "MPP"; and

WHEREAS, County finds it necessary to secure claims processing services for PSIP, PPP and MPP Programs; and

WHEREAS, Contractor is duly licensed and certified under the laws of the State of California to engage in the business of claims processing services, as described hereunder and possesses the competence, expertise, and personnel required to provide such services; and

WHEREAS, the authority of the County to enter into this Agreement is found in the HSC section 1452, Government Code sections 31000, 26227, and 53703, as well as Los Angeles County Code sections 2.121.250 et seq.

NOW, THEREFORE, the parties hereto agree as follows:

1. TERM OF AGREEMENT: This Agreement shall be effective upon Board approval, and shall continue in full force and effect through March 31, 2008. This Agreement shall be thereafter automatically renewed for four (4) additional twelve (12) month periods without further action by the parties hereto provided that funding is appropriated by the Board for each extended renewal period, unless the desire of either party not to renew the same is given in writing to the other party not less than thirty (30) calendar days prior to the end of any such twelve (12) month period. All provisions of the Agreement in effect on March 31, 2008, shall remain in effect for all renewal periods. Contractor shall be compensated according to the payment provisions and rate(s) specified in this Agreement.

2. TERMINATION OF AGREEMENT:

A. Notwithstanding any other provision in this Agreement, this Agreement shall be effective and binding upon the parties in each subsequent County July 1 - June 30 fiscal year only, or any portion thereof, in the event that funds for the purposes hereof are appropriated for such County fiscal year by County's Board of Supervisors. If such funds are not so appropriated, Agreement shall be

deemed to have terminated as of midnight, June 30, of the prior fiscal year. County shall notify Contractor in writing of such non-allocation of funds at the earliest possible date.

B. In the event of a material breach of this Agreement by either party, the other party may terminate this Agreement by giving written notice of termination specifying the material breach to the breaching party. Such termination shall be effective immediately upon delivery of written notice of termination to the breaching party.

C. Subparagraph B hereof notwithstanding, either party may terminate this Agreement, effective immediately upon written notice to the other party, if such other party should lose any material license, permit, or agreement required to enable such party to perform its obligations and duties under this Agreement.

D. Subparagraphs B and C hereof notwithstanding, either party may terminate this Agreement, effective immediately upon written notice to the other party, or at a later date as may be specified in such notice, if such other party files for bankruptcy, insolvency, reorganization, or the appointment of a receiver, trustee, or conservator for any of its assets, or makes an assignment for the benefit of its creditors, which termination shall be effective immediately upon delivery of, or on such later date as may be specified in such notice.

E. Subparagraphs B, C, and D hereof notwithstanding, either party may terminate this Agreement at any time and for any reason, with or without cause, by giving at least thirty (30) calendar days prior written notice of termination to the other party. Nonetheless, upon such termination, contractor must fully cooperate in the transition to the successor contractor by providing data, reports, etc., and assistance as requested by County.

3. DESCRIPTION OF SERVICES: Contractor shall provide claims processing services to County as specified in Exhibit A, PSIP Claims Adjudication, Exhibit B, PPP Program Claims Adjudication Services, and Exhibit C, MPP Claims Adjudication Services, attached hereto and incorporated herein by reference, in accordance with the payment provisions and rates specified in Exhibits A, B, and C, and each of their respective attachments and forms, all attached hereto and incorporated herein by reference.

Additional Services to be provided by Contractor at no additional cost to County: Contractor shall provide data entry services for claims submitted by Private Formula Hospitals as required to meet State Medically Indigent Care Reporting System (MICRS) and California Healthcare for Indigents Program (CHIP) reporting requirements. This includes creation of an electronic file format and transfer of hospital data to the Department's Information Resource Management Division.

4. MAXIMUM OBLIGATION

A. During the period effective upon Board approval through March 31, 2008, the maximum obligation for all program services provided under this Agreement shall not exceed $2.2 million.

1) That portion of the maximum obligation designated for PSIP and MPP Claims Adjudication Services shall not exceed $1.1 million and will be partially offset by any available State allocated Tobacco Tax and SB 612 administrative funds.

2) That portion of the maximum obligation designated for PPP Program Claims Adjudication Services shall not exceed $1.1 million in net County costs.

B. During the subsequent four (4) twelve-month automatic renewals, the total maximum obligation for all program services (PSIP, MPP and PPP) provided under this Agreement shall not exceed $9.0 million.

1) That portion of the maximum obligation designated for PSIP and MPP Claims Adjudication Services shall not exceed $4.6 million and will be partially offset by any available State allocated Tobacco Tax and SB 612 administrative funds.

2) That portion of the maximum obligation designated for PPP Program Claims

Adjudication Services shall not exceed $4.4 million in net County costs.

5. BILLING AND PAYMENT: Contractor shall bill County monthly in arrears in accordance with the fees set forth in Payment Paragraph of Exhibit A, PSIP Claims Adjudication Services, ~~and~~ Payment Paragraph of Exhibit B, PPP Program Claims Adjudication Services, and Payment Paragraph of Exhibit C, MPP Claims Adjudication Services, attached hereto. All billings shall clearly reflect and provide reasonable detail of services for which claim is made. County shall pay Contractor within a reasonable period of time following receipt of a complete and correct billing, as determined by County.

6. CONTRACT ADMINISTRATION: Director or his authorized designee shall have the authority to administer this Agreement on behalf of County.

7. CHANGE NOTICES AND AMENDMENTS:

A. County reserves the right to change any portion of the work requirement under this Agreement and any other provisions of this Agreement. All such changes shall be accomplished only as provided in this Paragraph.

B. For any changes which do not affect the scope of work, period of performance, payments, or any term or condition included in this Agreement, a Change Notice shall be prepared and executed by County's Project Manager.

C. For any change which affects the scope of work, period of performance, payments, or any term and condition

included in this Agreement, a negotiated Amendment to this Agreement shall be prepared and executed by County's Board of Supervisors and Contractor.

D. Notwithstanding any other provisions of this Paragraph, to the extent that extensions of time for Contractor performance do not impact either the scope of work or cost of this Agreement, County's Project Manager may, in his/her sole discretion, grant Contractor extensions of time, provided that the aggregate of all such extensions during the term of this Agreement shall not exceed sixty (60) days. Contractor agrees that such extensions shall not change any other term or condition of this Agreement during the periods of extension.

8. PARTIES' RELATIONSHIP:

A. This Agreement is not intended, and shall not be construed, to create the relationship of principal-agent, master-servant, employer-employee, business partnership, joint venture, or association, as between County and Contractor. The employees and agents of one party shall not be, or be construed to be, the employees or agents of the other party for any purpose whatsoever.

B. Contractor shall be solely liable and responsible for providing to, or on behalf of, its employees all legally required employee compensation and benefits. County shall have no liability or responsibility for the payment of any salaries, wages, unemployment benefits, disability benefits,

or other compensation or benefits, to any personnel provided by Contractor.

C. County shall be solely liable and responsible for providing to, or on behalf of, its employees all legally required employee compensation and benefits. Contractor shall have no liability or responsibility for the payment of any salaries, wages, unemployment benefits, disability benefits, or other compensation or benefits, to any personnel provided by County.

D. Contractor understands and agrees that all of its staff and employees furnishing services to County pursuant to this Agreement are, for purposes of workers' compensation liability, the sole employees of Contractor and not employees of County. Contractor shall bear the sole liability and responsibility for any and all workers' compensation benefits to any of its staff and employees as a result of injuries arising from or connected with services performed by or on behalf of Contractor pursuant to this Agreement.

E. A written acknowledgment that each of Contractor's staff and employees understands that such person is an employee of Contractor and not an employee of County shall be signed by each employee of Contractor performing services under this Agreement and shall be filed by Contractor with County's Department of Human Resources, Health, Safety, and Disability Benefits Division, 3333 Wilshire Boulevard, 10th

Floor, Los Angeles, California 90010. The form and content of such acknowledgment shall be substantially similar to the Contractor Employee Acknowledgment and Confidentiality form incorporated herein by reference.

9. SUBCONTRACTING: For purposes of this Agreement, subcontracts shall be approved by Director or his/her authorized designee(s). Contractor's request to Director for approval of a subcontract shall include:

1) Identification of the proposed subcontractor and an explanation of why and how the proposed subcontractor was selected, including a description of Contractor's efforts to obtain competitive bids.

2) A description of the services to be provided under the subcontract.

3) The proposed subcontract amount, together with Contractor's cost or price analysis thereof. In the event that the subcontracted services are to be provided to Contractor on either a gratuitous or "pro bono" or "volunteer" basis, Contractor shall state as such.

4) A copy of the proposed subcontract. Any later modification of such subcontract shall take the form of a formally written subcontract amendment, which must be approved in writing by Director before such amendment is effective.

A. Subcontracts issued pursuant to this Paragraph shall be in writing and shall contain at least the intent of all of the

Paragraphs of the body of the Agreement, and the requirements of the exhibit(s), including their attachments.

B. At least thirty (30) calendar days prior to the subcontract's proposed effective date, Contractor shall submit for review and approval to Director a copy of the proposed subcontract instrument. With Director's written approval of the subcontract instrument, the subcontract may proceed.

C. Subcontracts shall be made in the name of Contractor and shall not bind County. The making of subcontracts hereunder shall not relieve Contractor of any requirement under this Agreement, including, but not limited to, the duty to properly supervise and coordinate the work of subcontractors. Approval of the provisions of any subcontract by County shall not be construed to constitute a determination of the allowability of any cost under this Agreement. In no event shall approval of any subcontract by County be construed as affecting any increase to the amount contained in the MAXIMUM OBLIGATION Paragraph.

D. Failure by Contractor to comply with this Paragraph shall constitute a material breach of contract upon which County may immediately terminate or suspend this Agreement. County, at its sole option, may obtain damages from Contractor resulting from said breach.

10. INDEMNIFICATION: Contractor shall indemnify, defend, and hold harmless County and its Special Districts, elected and appointed officers, employees, and agents from and against any and all liability, including but not limited to demands, claims,

actions, fees, costs, and expenses (including attorney and expert witness fees), arising from or connected with Contractor's acts and/or omissions arising from and/or relating to this Agreement.

11. GENERAL INSURANCE REQUIREMENTS: Without limiting Contractor's indemnification of County, and during the term of this Agreement, Contractor shall provide and maintain, and shall require all of its subcontractors to maintain, the following programs of insurance specified in this Agreement. Such insurance shall be primary to and not contributing with any other insurance or self-insurance programs maintained by County, and such coverage shall be provided and maintained at Contractor's own expense.

A. Evidence of Insurance: Certificate(s) or other evidence of coverage satisfactory to County shall be delivered to County's Department of Health Services, Contracts and Grants Division, 313 North Figueroa Street, Sixth Floor-East, Los Angeles, California 90012, prior to commencing services under this Agreement. Such certificates or other evidence shall:

(1) Specifically identify this Agreement.

(2) Clearly evidence all coverages required in this Agreement.

(3) Contain the express condition that County is to be given written notice by mail at least thirty (30) calendar days in advance of cancellation for all policies evidenced on the certificate of insurance.

(4) Include copies of the additional insured endorsement to the commercial general liability policy, adding County of Los Angeles, its Special Districts, its officials, officers, and employees as insureds for all activities arising from this Agreement.

(5) Identify any deductibles or self-insured retentions for County's approval. County retains the right to require Contractor to reduce or eliminate such deductibles or self-insured retentions as they apply to County, or, require Contractor to provide a bond guaranteeing payment of all such retained losses and related costs, including, but not limited to, expenses or fees, or both, related to investigations, claims administrations, and legal defense. Such bond shall be executed by a corporate surety licensed to transact business in the State of California.

B. Insurer Financial Ratings: Insurance is to be provided by an insurance company acceptable to County with an A.M. Best rating of not less than A:VII, unless otherwise approved by County.

C. Failure to Maintain Coverage: Failure by Contractor to maintain the required insurance, or to provide evidence of insurance coverage acceptable to County, shall constitute a material breach of contract upon which County may immediately terminate or suspend this Agreement. County, at its sole option, may obtain damages from

Contractor resulting from said breach. Alternatively, County may purchase such required insurance coverage, and without further notice to Contractor, County may deduct from sums due to Contractor any premium costs advanced by County for such insurance.

D. Notification of Incidents, Claims, or Suits: Contractor shall report to County:

(1) Any accident or incident relating to services performed under this Agreement which involves injury or property damage which may result in the filing of a claim or lawsuit against Contractor and/or County. Such report shall be made in writing within twenty-four (24) hours of occurrence.

(2) Any third party claim or lawsuit filed against Contractor arising from or related to services performed by Contractor under this Agreement.

(3) Any injury to a Contractor employee which occurs on County property. This report shall be submitted on a County "Non-Employee Injury Report" to County contract manager.

(4) Any loss, disappearance, destruction, misuse, or theft of any kind whatsoever of County property, monies, or securities entrusted to Contractor under the terms of this Agreement.

E. Compensation for County Costs: In the event that Contractor fails to comply with any of the indemnification

or insurance requirements of this Agreement, and such failure to comply results in any costs to County, Contractor shall pay full compensation for all costs incurred by County.

F. Insurance Coverage Requirements for Subcontractors: Contractor shall ensure any and all subcontractors performing services under this Agreement meet the insurance requirements of this Agreement by either:

(1) Contractor providing evidence of insurance covering the activities of subcontractors, or

(2) Contractor providing evidence submitted by subcontractors evidencing that subcontractors maintain the required insurance coverage. County retains the right to obtain copies of evidence of subcontractor insurance coverage at any time.

12. INSURANCE COVERAGE REQUIREMENTS:

A. General Liability Insurance (written on Insurance Services Office [ISO] policy form CG 00 01 or its equivalent) with limits of not less than the following:

General Aggregate:	$2 Million
Products/Completed Operations Aggregate:	$1 Million
Personal and Advertising Injury:	$1 Million
Each Occurrence:	$1 Million

B. Workers' Compensation and Employers' Liability: Insurance providing workers' compensation benefits, as

required by the Labor Code of the State of California or by any other state, and for which Contractor is responsible.

In all cases, the above insurance shall include Employers' Liability coverage with limits of not less than the following:

Each Accident:	$1 Million
Disease - Policy Limit:	$1 Million
Disease - Each Employee:	$1 Million

C. Professional Liability: Insurance covering liability arising from any error, omission, negligent or wrongful act of Contractor, its officers or employees with limits of not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) aggregate. The coverage also shall provide an extended two-year reporting period commencing upon expiration or earlier termination or cancellation of this Agreement.

13. INDEMNIFICATION AND INSURANCE APPLICATION TO SUBCONTRACTOR(S): Contractor shall ensure that its subcontractor(s) providing services under this Agreement meet the requirements of the INDEMNIFICATION AND INSURANCE Paragraphs hereinabove, and shall ensure that all subcontract documents hereunder include such requirements.

14. REPORTS: Contractor shall make reports as required by Director concerning Contractor's activities and operations as they relate to the services hereunder. In no event, however, may County require such reports unless Director has provided

Contractor with at least thirty (30) calendar days prior written notification thereof, unless the report is of a critical nature requiring a reduced notification period, at the Director's discretion. The specific information required and the report format shall be determined by Director, and may be revised from time-to-time.

15. RECORDS AND AUDITS:

A. Contractor shall maintain accurate and complete financial records of its operations as they relate to the services provided under this Agreement in accordance with generally accepted accounting principles and procedures. Contractor shall also maintain accurate and complete employment and other records of all services provided hereunder. All such records shall be retained by Contractor for a minimum period of five (5) years following the expiration or termination of this Agreement.

During such five (5) year period, as applicable, as well as during the term of this Agreement, all such records or true and correct copies thereof pertaining to this Agreement, including but not limited to those described above, and all additional documents which bear any reasonable relationship whatsoever to this Agreement, shall be retained by Contractor at a location in Los Angeles County.

A. Audit Reports: In the event that an annual audit is conducted pertaining to the financial condition of

Contractor by any Federal or State auditor, or any auditor or accountant employed by Contractor or otherwise, Contractor shall file a copy of each such annual audit with County's Department of Auditor-Controller and Department of Health Services, Inspection and Audit Division, within ten (10) calendar days of Contractor's receipt thereof, unless otherwise provided under this Agreement or under applicable Federal or State law. County shall make a reasonable effort to maintain the confidentiality of such audit report(s).

B. Audit/Compliance Review: County staff designated by Director, or Federal or State representatives, may conduct a statistical audit/compliance review of all claims paid by County during a specified time period. If the audit is conducted by County staff, any sampling shall be determined in accordance with generally accepted auditing standards, and an exit conference shall be held following the performance of such audit/compliance review at which time the results shall be discussed with Contractor. Contractor shall be provided with a copy of any written evaluation reports prepared by County staff.

If the claims review is conducted by County staff, Contractor shall have the opportunity to review County's findings for Contractor, and Contractor shall have thirty (30) calendar days after receipt of County's audit/ compliance review results to provide documentation to County representatives to resolve the audit exceptions. If, at the

end of the thirty (30) calendar day period, audit exceptions remain which have not been resolved to the satisfaction of County's representatives, then the exception rate found in the audit or sample shall be applied to the total County payment made to Contractor for all claims paid during the audit/compliance review period to determine Contractor's liability to County.

C. County Audit Settlements: At any time during the term of this Agreement or at any time after the expiration or earlier termination of this Agreement, authorized representatives of County may conduct an audit of Contractor regarding the services provided to County hereunder.

If Director determines at any time that Contractor has been overpaid, following Director's written notice, the amount of the overpayment shall be paid immediately by Contractor to County.

If Director determines that Contractor has been underpaid, the amount of the underpayment shall be paid within a reasonable time to Contractor. However, County shall not pay to Contractor an amount in excess of County's maximum obligation under this Agreement, except as may be expressly specified elsewhere in Agreement.

Failure of Contractor to comply with any one or more of the provisions of this Paragraph shall constitute a material breach of contract upon which County may terminate or suspend this Agreement.

16. STATE AND FEDERAL ACCESS TO RECORDS:

A. State Access to Records: Contractor agrees to maintain and preserve, until five (5) years after termination of this Agreement, and to permit the State of California ("State") or any of its duly authorized representatives, to have access to and to examine and audit any pertinent books, documents, papers, and records of Contractor.

B. Federal Access to Records: If and to the extent that, section 1861(v)(1)(I) of the Social Security Act (42 U.S.C. section 1395x(v)(1)(I)) is applicable, Contractor agrees that for a period of three (3) years following the furnishing of services under this Agreement, Contractor shall maintain and make available, upon written request, to the Secretary of the United States Department of Health and Human Services or the Comptroller General of the United States, or to any of their authorized representative, the contracts, books, documents, and records of Contractor which are necessary to verify the nature and extend of the costs of services provided hereunder.

17. COPYRIGHTS/RIGHTS TO DATA:

A. Subject Data: As used in this clause, the term "Subject Data" means writings, audiovisual, designs, procedural manuals, forms, data files, and data processing or computer programs, and works of any similar nature ("whether or not copyrighted or copyrightable") which are

first produced or developed under this Agreement. The term does not include financial reports, costs analysis, and similar information incidental to contract administration.

Contractor shall be prohibited from copyrighting any data, publications, or materials, whether written or audiovisual, first produced or developed from work supported by County during the term of this Agreement. Additionally, County, State, and Federal Governments may use, duplicate, or disclose in any manner and for any purpose whatsoever, and permit others to do so, all Subject Data produced under this Agreement.

B. Federal Government, State, and County Rights: Subject only to the provisions of Subparagraph C below, the Federal Government, State, and County may use, duplicate, or disclose in any manner and for any purpose whatsoever, and permit others to do so, all Subject Data produced under this Agreement.

C. License to Copyrighted Data: In addition to the Federal Government, State, and County rights as provided in Subparagraph B above, with respect to any Subject Data which may be copyrighted, Contractor agrees to and does hereby grant to Federal Government, State, and County a royalty-free, nonexclusive, and irrevocable license to use, duplicate, or disclose Subject Data in any manner for Federal Government, State, and County purposes and to have or permit others to do so.

18. TRADE SECRETS: Recognizing that County has no way to safeguard trade secrets or proprietary information, Contractor shall and does hereby keep and hold County harmless from all damages, costs, and expenses by reason of any disclosure by County of Contractor trade secrets and proprietary information.

19. NONDISCRIMINATION IN EMPLOYMENT:

A. Contractor certifies and agrees that all persons employed by it, its affiliates, subsidiaries, or holding companies, are and will be treated equally by it without regard to or because of race, color, religion, national origin, ancestry, sex, age, or condition of physical disability (including HIV and AIDS) or mental disability, marital status, medical condition (cancer), denial of family care leave, or political affiliation, and in compliance with all applicable Federal and State anti-discrimination laws and regulations.

B. Contractor shall take affirmative action to ensure that qualified applicants are employed. Contractor shall not discriminate against or harass, nor shall it permit harassment of, its employees during employment based upon race, color, religion, national origin, ancestry, sex, age, or condition of physical disability (including HIV and AIDS) or mental disability, marital status, medical condition (cancer), denial of family care leave, or political affiliation in compliance with all applicable Federal and State anti-discrimination laws and regulations. Such action

shall include, but is not limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. Contractor shall insure that the evaluation and treatment of its employees and applicants for employment are free from such discrimination and harassment, and will comply with the provisions of the Fair Employment and Housing Act (Government Code section 12990 et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, section 7285.0 et seq.)

C. Contractor shall deal with its subcontractors, bidders, or vendors without regard to or because of race, color, religion, national origin, ancestry, sex, age, or condition of physical disability (including HIV and AIDS) or mental disability, marital status, medical condition (cancer), denial of family care leave, or political affiliation. Further, Contractor shall give written notice of its obligations under this Paragraph to labor organizations with which it has a collective bargaining or other agreement.

D. Contractor shall allow County representatives access to relevant portions of its employment records of employees providing services at County's Facility or Contractor's facility, as applicable, during regular

business hours to verify compliance with the provision of this Paragraph when so requested by Director.

E. If County finds that any of the above provisions have been violated, the same shall constitute a material breach of this Agreement upon which County may determine to cancel, terminate, or suspend this Agreement. While County reserves the right to determine independently that the anti-discrimination provisions of this Agreement have been violated, in addition, a determination by the California Fair Employment Practices Commission or the Federal Equal Employment Opportunity Commission that Contractor has violated Federal or State anti-discrimination laws or regulations shall constitute a finding by County that Contractor has violated the anti-discrimination provisions of this Agreement.

F. The parties agree that in the event that Contractor violates the anti-discrimination provisions of this Agreement, County shall, at its option, be entitled to a sum of Five Hundred Dollars ($500) pursuant to California Civil Code Section 1672 as liquidated damages in lieu of canceling, terminating, or suspending this Agreement.

20. ASSIGNMENT BY CONTRACTOR:

A. The Contractor shall not assign its rights or delegate its duties under this Agreement, or both, whether in whole or in part, without the prior written consent of County, in its discretion, and any attempted assignment or

delegation without such consent shall be null and void. For purposes of this paragraph, County consent shall require a written amendment to the Agreement, which is formally approved and executed by the parties. Any payments by the County to any approved delegatee or assignee on any claim under this Agreement shall be deductible, at County's sole discretion, against the claims, which the Contractor may have against the County.

B. Shareholders, partners, members, or other equity holders of Contractor may transfer, sell, exchange, assign, or divest themselves of any interest they may have therein. However, in the event any such sale, transfer, exchange, assignment, or divestment is effected in such a way as to give majority control of Contractor to any person(s), corporation, partnership, or legal entity other than the majority controlling interest therein at the time of execution of the Agreement, such disposition is an assignment requiring the prior written consent of County in accordance with applicable provisions of this Agreement.

C. If any assumption, assignment, delegation, or takeover of any of the Contractor's duties, responsibilities, obligations, or performance of same by any entity other than the Contractor, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever without County's express prior written

approval, shall be a material breach of the Contract which may result in the termination of this Agreement. In the event of such termination, County shall be entitled to pursue the same remedies against Contractor as it could pursue in the event of default by Contractor.

21. LICENSES, PERMITS, REGISTRATIONS, CERTIFICATES, AND COMPLIANCE WITH APPLICABLE LAW: Contractor shall obtain and maintain in effect during the term of this Agreement, all licenses, permits, registrations, and certificates required by law which are applicable to its performance of this Agreement, and shall ensure that all its officers, employees, volunteers, and agents who perform services hereunder obtain and maintain in effect during the term of this Agreement, all licenses, permits, registrations, and certificates required by law which are applicable to their performance hereunder.

Contractor shall comply with all with all Federal, State, and local laws, ordinances, regulations, rules, and directives applicable to its performance hereunder. Further, all provisions required thereby to be included in this Agreement are hereby incorporated herein by reference.

22. GOVERNING LAWS, JURISDICTION, AND VENUE: This Agreement shall be governed by, and construed in accordance with, the laws of the State of California. Contractor agrees and consents to the exclusive jurisdiction of the courts of the State of California for all purposes regarding this Agreement and

further agrees and consents that venue of any action brought hereunder shall be exclusively in Los Angeles County.

23. ARBITRATION: The parties shall meet and confer to resolve any dispute regarding the implementation or interpretation of this Agreement. Such informal process may be initiated, by either party, by written notice given by the initiating party to the other party in accordance with the provisions of the NOTICES Paragraph in the body of this Agreement.

In the event the parties are unable to resolve a dispute informally within thirty (30) calendar days of the date such written notice was delivered, either party may submit the matter to arbitration, upon written notice thereof to the other party. The arbitration shall be conducted by a single neutral arbitrator selected in accordance with the Commercial Arbitration Rules of the American Arbitration Association. The arbitrator shall conduct the arbitration in accordance with such rules. The above notwithstanding, the California rules of discovery (California Code of Civil Procedure, section 2016 et. seq) shall apply to any such arbitration. The judgment rendered by the arbitrator shall be final and binding on the parties. Reasonable legal fees and costs of the prevailing party, as well as the costs of arbitration shall be borne by the non-prevailing party, unless the arbitrator expressly determines to the contrary; provided, however, that in no event shall the prevailing party be

responsible for more than its legal fees and costs, or for more than one-half of the costs of arbitration.

Nothing herein is intended to foreclose any other rights under Agreement that each party may have to terminate or suspend Agreement.

24. RESTRICTIONS ON LOBBYING: Contractor shall comply with all certification and disclosure requirements prescribed by section 319, Public Law 101-121 (Title 31, United States Code, section 1352) and any implementing regulations, and shall ensure that each of its subcontractors receiving funds provided under this Agreement also fully complies with all such certification and disclosure requirements.

25. COUNTY LOBBYISTS: Contractor and each lobbyist or lobbying firm (as defined in Los Angeles County Code section 2.160.010) retained by Contractor, shall fully comply with the County Lobbyist Ordinance, Los Angeles County Code Chapter 2.160. Failure on the part of Contractor or any County lobbyist or County lobbying firm retained by Contractor to fully comply with the County Lobbyist Ordinance shall constitute a material breach of this Agreement upon which County may immediately terminate or suspend this Agreement.

26. UNLAWFUL SOLICITATION: Contractor shall inform all of its employees providing services hereunder of the provisions of Article 9 of Chapter 4 of Division 3, commencing with section 6150, of the Business and Professions Code of the State of California (i.e., State Bar Act provisions regarding unlawful

solicitation as a runner or capper for attorneys) and shall take positive and affirmative steps in its performance hereunder to ensure that there is no violation of said provisions by its officers, employees, agents, or volunteers. Contractor shall utilize the attorney referral service of all those bar associations within Los Angeles County that have such a service.

27. CONFLICT OF INTEREST: No County employee whose position with County enables such employee to influence the award of this Agreement or any competing agreement, and no spouse or economic dependent of such employee, shall be employed in any capacity by Contractor or have any other direct or indirect financial interest in this Agreement. No officer or employee of Contractor, who may financially benefit from the performance of work hereunder, shall in any way participate in County's approval, or ongoing evaluation, of such work, or in any way attempt to unlawfully influence County's approval or ongoing evaluation of such work.

Contractor shall comply with all conflict of interest laws, ordinances, and regulations now in effect or hereafter to be enacted during the term of this Agreement. Contractor warrants that it is not now aware of any facts which create a conflict of interest. If Contractor hereafter becomes aware of any facts which might reasonably be expected to create a conflict of interest, it shall immediately make full written disclosure of such facts to County. Full written disclosure shall include, but

is not limited to, identification of all persons implicated and a complete description of all relevant circumstances.

28. CONFIDENTIALITY: Contractor shall maintain the confidentiality of all records, data, and information, including, but not limited to, billings, County records and data, and other information obtained from County under this Agreement, in accordance with all applicable Federal, State, and local laws, ordinances, guidelines and directives relating to confidentiality.

Contractor shall inform all its officers, employees, and agents providing services hereunder of the confidentiality provisions of this Agreement. Contractor shall provide to County an executed Contractor Employee Acknowledgment and Confidentially Agreement, Exhibit D, for each of its employees performing work under this Agreement in accordance with the INDEPENDENT CONTRACTOR STATUS Paragraph. Contractor shall provide to County an executed Contractor Non-Employee Acknowledgment and Confidentiality Agreement, Exhibit D-1, of each of its non-employees performing work under this Agreement in accordance with the INDEPENDENT CONTRACTOR STATUS Paragraph.

Contractor shall indemnify, defend and hold harmless County, its officers, employees and agents, from and against any and all loss, damage, liability and expense, including, but not limited to, defense costs and legal accounting and other expert, consulting or professional fees, arising from any disclosure of such records and information by Contractor, its officers,

employees or agents, except for any disclosure authorized by this Paragraph.

29. FAIR LABOR STANDARDS ACT: Contractor shall comply with all applicable provisions of the Federal Fair Labor Standards Act, and shall indemnify, defend, and hold harmless County, its agents, officers, and employees from any and all liability including, but not limited to, wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law including, but not limited to, the Federal Fair Labor Standards Act for services performed by Contractor's employees for which County may be found jointly or solely liable.

30. EMPLOYEE ELIGIBILITY VERIFICATION: Contractor warrants that it fully complies with all Federal statutes and regulations regarding employment of aliens and others, and that all its employees performing services hereunder meet the citizenship or alien status requirements contained in Federal statutes and regulations. Contractor shall obtain, from all covered employees performing services hereunder, all verification and other documentation of employment eligibility status required by Federal statutes and regulations, as they currently exist and as they may be hereafter amended. Contractor shall retain such documentation for all covered employees for the period prescribed by law. Contractor shall indemnify, defend, and hold harmless County, its officers, agents, and employees from employer sanctions and any other liability which may be assessed against

Contractor or County in connection with any alleged violation of Federal statutes or regulations pertaining to the eligibility for employment of persons performing services under this Agreement.

31. INDEPENDENT CONTRACTOR STATUS:

A. This Agreement is by and between County and Contractor and is not intended, and shall not be construed, to create the relationship of employee, agent, servant, partnership, joint venture, or association, as between County and Contractor. The employees and agents of one party shall not be, or be construed to be, the employees or agents of the other party for any purpose whatsoever.

B. Contractor shall be solely liable and responsible for providing to, or on behalf of, its employees all legally required employee benefits. County shall have no liability or responsibility for the payment of any salaries, wages, unemployment benefits, disability benefits, Federal, State, and local taxes, or other compensation, benefits, or taxes to any personnel provided by Contractor.

C. Contractor understands and agrees that all persons furnishing services to County pursuant to this Agreement are, for purposes of workers' compensation liability, the sole employees of Contractor and not employees of County. Contractor shall bear the sole responsibility and liability for any and all workers' compensation benefits to any person as a result of injuries arising from or connected with

services performed by or on behalf of Contractor pursuant to this Agreement.

32. WAIVER: No waiver of a breach of any provision of this Agreement by County shall constitute a waiver of any other breach of such provision. Failure of County to enforce at anytime, or from time to time, any provision of this Agreement shall not be construed as a waiver thereof. The remedies herein reserved shall be cumulative and in addition to any other remedies in law or equity.

33. SEVERABILITY: If any provision of this Agreement or the application thereof to any person or circumstances is held invalid, the remainder of this Agreement and the application of such provision to other persons or circumstances shall not be affected thereby.

34. AUTHORIZED WARRANTY: Contractor hereby represents and warrants that the person executing this Agreement for Contractor is an authorized agent who has actual authority to bind Contractor to each and every term, condition, and obligation set forth in this Agreement and that all requirements of Contractor have been fulfilled to provide such actual authority.

35. CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: Contractor acknowledges that County has established a goal of ensuring that all individuals who benefit financially from County through contract are in compliance with their court-ordered child, family, and spousal

support obligations in order to mitigate the economic burden otherwise imposed upon County and its taxpayers.

As required by County's Child Support Compliance Program (County Code Chapter 2.200) and without limiting Contractor's duty under this Agreement to comply with all applicable provisions of law, Contractor warrants that it is now in compliance and shall during the term of this Agreement maintain compliance with employment and wage reporting requirements as required by the federal Social Security Act [(42 USC section 653 (a)] and California Unemployment Insurance Code section 1088.55, and shall implement all lawfully served Wage and Earnings Withholding Orders or Child Support Services Department ("CSSD") Notices of Wage and Earnings Assignment for Child, Family, or Spousal Support, pursuant to Code of Civil Procedure section 706.031 and Family Code section 5246(b).

36. TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: Failure of Contractor to maintain compliance with the requirements set forth in the CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM Paragraph, immediately above, shall constitute default by Contractor under this Agreement. Without limiting the rights and remedies available to County under any other provision of this Agreement, failure to cure such default within ninety (90) calendar days of written notice shall be grounds upon which County's Board of Supervisors may terminate this Agreement pursuant to the

TERMINATION Paragraph of this Agreement and pursue debarment of Contractor, pursuant to County Code Chapter 2.202.

37. CONTRACTOR'S ACKNOWLEDGMENT OF COUNTY'S COMMITMENT TO CHILD SUPPORT ENFORCEMENT: Contractor acknowledges that County places a high priority on the enforcement of child support laws and the apprehension of child support evaders. Contractor understands that it is County's policy to encourage all County Contractors to voluntarily post County's "L.A.'s Most Wanted: Delinquent Parents" poster in a prominent position at Contractor's place of business. County's CSSD will supply Contractor with the poster to be used.

38. CONSIDERATION OF HIRING GAIN/GROW PROGRAM PARTICIPANTS: Should Contractor require additional or replacement personnel after the effective date of this Agreement, Contractor shall give consideration for any such employment openings to participants in the County's Department of Public Social Services' Greater Avenues for Independence ("GAIN") Program or General Relief Opportunity for Work ("GROW") Program who meet Contractor's minimum qualifications for the open position. For this purpose, consideration shall mean that Contractor will interview qualified candidates. County will refer GAIN/GROW participants by job category to the Contractor.

In the event that both laid-off County employees and GAIN/GROW participants are available for hiring, County employees shall be given first priority.

39. COUNTY EMPLOYEES: To the degree permitted by Contractor's agreements with its Collective Bargaining Units, should Contractor require additional or replacement personnel after the effective date of this Agreement to perform the services set forth herein, Contractor shall give consideration for such employment openings to qualified permanent County employees who are targeted for layoff or qualified former County employees who are on a re-employment list during the term of this Agreement. Such offers of employment shall be limited to vacancies in Contractor's staff needed to commence services under this Agreement, as well as to vacancies that occur during the Agreement term. Such offers of employment shall be consistent with Contractor's current employment policies, and shall be made to any former or current County employee who has made application to Contractor, and is qualified for the available position. Employment offers shall be at least under the same conditions and rates of compensations which apply to other persons who are employed or may be employed by Contractor.

Contractor shall also give consideration to laid-off or reduced County employees if vacancies occur at Contractor's other service sites during the Agreement term.

40. COUNTY'S QUALITY ASSURANCE PLAN: County or its agent will evaluate Contractor's performance under this Agreement on not less than an annual basis. Such evaluation will include assessing Contractor's compliance with all contract terms and performance standards. Contractor deficiencies which County

determines are severe or continuing and that may place performance of this Agreement in jeopardy if not corrected will be reported to County's Board of Supervisors. The report will include improvement/corrective action measures taken by County and Contractor. If improvement does not occur consistent with the corrective measures, County may terminate this Agreement or impose other penalties as specified in this Agreement.

41. CONTRACTOR'S OBLIGATIONS AS "BUSINESS ASSOCIATE" UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT: Under this Agreement, Contractor ("Business Associate") provides services ("Services") to County ("Covered Entity") and Business Associate receives, has access to or creates Protected Health Information in order to provide those Services. Covered Entity is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information ("Privacy Regulations") and the Health Insurance Reform: Security Standards ("the Security Regulations") at 45 Code of Federal Regulations Parts 160 and 164 ("together, the "Privacy and Security Regulations").

The Privacy and Security Regulations require Covered Entity to enter into a contract with Business Associate in order to mandate certain protections for the privacy and security of Protected Health Information, and those Regulations prohibit the disclosure to or use of Protected Health Information by Business

Associate if such a contract is not in place;

Therefore, the parties agree as follows:

A. DEFINITIONS:

1) "Disclose" and "Disclosure" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its employees.

2) "Electronic Media" has the same meaning as the term "electronic media" in 45 C.F.R. § 160.103. Electronic Media means (1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

The term "Electronic Media" draws no distinction between internal and external data, at rest (that is, in storage) as well as during transmission.

3) "Electronic Protected Health Information" has the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103. Electronic Protected Health Information means Protected Health Information that is (i) transmitted by electronic media; (ii) maintained in electronic media.

4) "Individual" means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

5) "Protected Health Information" has the same meaning as the term "protected health information" in 45 C.F.R. § 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity. Protected Health Information includes information that (i) relates to the past, present or future physical or mental health or condition of an Individual; the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is received by Business Associate from or on behalf of

Covered Entity, or is created by Business Associate, or is made accessible to Business Associate by Covered Entity. "Protected Health Information" includes Electronic Health Information.

6) "Required By Law" means a mandate contained in law that compels an entity to make a Use or Disclosure of Protected Health Information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or any administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

7) "Security Incident" means the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information in, or interference with system operations of, an Information System which contains Electronic Protected Health Information. However, Security Incident does not include attempts to access an Information System when those attempts

are not reasonably considered by Business Associate to constitute an actual threat to the Information System.

8) "Services" has the same meaning as in the body of this Agreement.

9) "Use" or "Uses" mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate's internal operations.

10) Terms used, but not otherwise defined in this Paragraph shall have the same meaning as those terms in the HIPAA Regulations.

B. OBLIGATIONS OF BUSINESS ASSOCIATE

1) Permitted Uses and Disclosures of Protected Health Information. Business Associate:

(a) shall Use and Disclose Protected Health Information as necessary to perform the Services, and as provided in Sections 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 4.3 and 5.2 of this Agreement;

(b) shall Disclose Protected Health Information to Covered Entity upon request;

(c) may, as necessary for the proper management and administration of its business or to carry out its legal responsibilities:

(i) Use Protected Health Information; and

(ii) Disclose Protected Health Information if the Disclosure is Required by Law.

Business Associate shall not Use or Disclose Protected Health Information for any other purpose.

2) Adequate Safeguards for Protected Health Information. Business Associate:

(a) Shall implement and maintain appropriate safeguards to prevent the Use or Disclosure of Protected Health Information in any manner other than as permitted by this Paragraph. Business Associate agrees to limit the Use and Disclosure of Protected Health Information to the minimum necessary in accordance with the Privacy Regulation's minimum necessary standard.

(b) effective as of April 20, 2005, specifically as to Electronic Health Information, shall implement and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information.

3) Reporting Non-Permitted Use or Disclosure and Security Incidents. Business Associate shall report to Covered Entity each Use or Disclosure that is made by Business Associate, its employees, representatives, agents or subcontractors but is not specifically permitted by this Agreement, as well as, effective as of April 20, 2005, each Security Incident of which Business Associate becomes aware. The initial report shall be made by telephone call to the

Departmental Privacy Officer, telephone number 1(800) 711-5366 within forty-eight (48) hours from the time the Business Associate becomes aware of the non-permitted Use or Disclosure or Security Incident, followed by a full written report no later than ten (10) business days from the date the Business Associate becomes aware of the non-permitted Use or Disclosure or Security Incident to the Chief Privacy Officer

at: Chief Privacy Officer
Kenneth Hahn Hall of Administration
500 West Temple St., Suite 525
Los Angeles, CA 90012

4) Mitigation of Harmful Effect. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of Protected Health Information by Business Associate in violation of the requirements of this Paragraph.

5) Availability of Internal Practices, Books and Records to Government Agencies. Business Associate agrees to make its internal practices, books and records relating to the Use and Disclosure of Protected Health Information available to the Secretary of the federal Department of Health and Human Services for purposes of determining Covered Entity's compliance with the Privacy and Security Regulations. Business Associate shall immediately notify Covered Entity of any requests made by the Secretary and provide Covered Entity with copies of any documents produced

in response to such request.

6) Access to Protected Health Information. Business Associate shall, to the extent Covered Entity determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make the Protected Health Information specified by Covered Entity available to the Individual(s) identified by Covered Entity as being entitled to access and copy that Protected Health Information. Business Associate shall provide such access for inspection of that Protected Health Information within two (2) business days after receipt of request from Covered Entity. Business Associate shall provide copies of that Protected Health Information within five (5) business days after receipt of request from Covered Entity.

7) Amendment of Protected Health Information. Business Associate shall, to the extent Covered Entity determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make any amendments to Protected Health Information that are requested by Covered Entity. Business Associate shall make such amendment within ten (10) business days after receipt of request from Covered Entity in order for Covered Entity to meet the requirements under 45 C.F.R. § 164.526.

8) Accounting of Disclosures. Upon Covered Entity's request, Business Associate shall provide to Covered Entity an accounting of each Disclosure of Protected Health

Information made by Business Associate or its employees, agents, representatives or subcontractors.

[Optional, to be used when all Uses and Disclosures permitted in order to perform the Services will be for the Covered Entity's payment or health care operations activities: However, Business Associate is not required to provide an accounting of Disclosures that are necessary to perform the Services because such Disclosures are for either payment or health care operations purposes, or both.]

Any accounting provided by Business Associate under this Section 2.8 shall include: (a) the date of the Disclosure; (b) the name, and address if known, of the entity or person who received the Protected Health Information; (c) a brief description of the Protected Health Information disclosed; and (d) a brief statement of the purpose of the Disclosure. For each Disclosure that could require an accounting under this Section 2.8, Business Associate shall document the information specified in (a) through (d), above, and shall securely maintain the information for six (6) years from the date of the Disclosure. Business Associate shall provide to Covered Entity, within ten (10) business days after receipt of request from Covered Entity, information collected in accordance with this Section 2.8 to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

C. OBLIGATION OF COVERED ENTITY: Covered Entity shall notify Business Associate of any current or future restrictions

or limitations on the use of Protected Health Information that would affect Business Associate's performance of the Services, and Business Associate shall thereafter restrict or limit its own uses and disclosures accordingly.

D. TERM AND TERMINATION

1) Term. The term of this Paragraph shall be the same as the term of this Agreement. Business Associate's obligations under Sections 2.1 (as modified by Section 4.2), 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 4.3 and 5.2 shall survive the termination or expiration of this Agreement.

2) Termination for Cause. In addition to and notwithstanding the termination provisions set forth in this Agreement, upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

(a) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

(b) Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or

(c) If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary of the federal Department of Health and Human Services.

3) Disposition of Protected Health Information Upon Termination or Expiration.

(a) Except as provided in paragraph (b) of this section, upon termination for any reason or expiration of this Agreement, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(b) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make infeasible. If return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

E. MISCELLANEOUS

1) No Third Party Beneficiaries. Nothing in this

Paragraph shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

2) Use of Subcontractors and Agents. Business Associate shall require each of its agents and subcontractors that receive Protected Health Information from Business Associate, or create Protected Health Information for Business Associate, on behalf of Covered Entity, to execute a written agreement obligating the agent or subcontractor to comply with all the terms of this Paragraph.

3) Relationship to Services Agreement Provisions. In the event that a provision of this Paragraph is contrary to another provision of this Agreement, the provision of this Paragraph shall control. Otherwise, this Paragraph shall be construed under, and in accordance with, the terms of this Agreement.

4) Regulatory References. A reference in this Paragraph to a section in the Privacy or Security Regulations means the section as in effect or as amended.

5) Interpretation. Any ambiguity in this Paragraph shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy and Security Regulations.

6) Amendment. The parties agree to take such action as is necessary to amend this Paragraph from time to time as is necessary for Covered Entity to comply with the

requirements of the Privacy and Security Regulations.

42. COMPLIANCE WITH JURY SERVICE PROGRAM: This Contract is subject to the provisions of the County's ordinance entitled Contractor Employee Jury Service ("Jury Service Program") as codified in Sections 2.203.010 through 2.203.090 of the Los Angeles Code.

A. Unless Contractor has demonstrated to the County's satisfaction either that Contractor is not a "Contractor" as defined under the Jury Service Program (Section 2.203.020 of the County Code) or that Contractor qualifies for an exception to the Jury Service Program (Section 2.203.070 of the County Code), Contractor shall have and adhere to a written policy that provides its Employees shall receive from the Contractor, on an annual basis, no less than five (5) days of regular pay for actual jury service. The policy may provide that Employees deposit any fees received for such jury service with the Contractor or that the Contractor deduct from the Employee's regular pay the fees received for jury service.

B. For purposes of this subparagraph, "Contractor" means a person, partnership, corporation or other entity which has a contract with the County and has received or will receive an aggregate sum of $50,000 or more in any 12-month period under one or more County contracts or subcontracts. "Employee" means any California resident who is a full-time employee of Contractor. "Full-time" means 40

hours or more worked per week, or a lesser number of hours if: 1) the lesser number is a recognized industry standard as determined by the County, or 2) Contractor has a long-standing practice that defines the lesser number of hours as full-time. Full time employees providing short term, temporary services of ninety (90) days or less within a 12 month period are not considered full time for purposes of the Jury Service Program.

C. If Contractor is not required to comply with the Jury Service Program when the Contract commences, Contractor shall have a continuing obligation to review the applicability of its "exception status" from the Jury Service Program, and Contractor shall immediately notify County if Contractor at any time either comes within the Jury Service Program's definition of "Contractor" or if Contractor no longer qualifies for an exception to the Jury Service Program. In either event, Contractor shall immediately implement a written policy consistent with the Jury Service Program. The County may also require, at any time during the Contract and at its sole discretion, that Contractor demonstrate to the County's satisfaction that Contractor either continues to remain outside of the Jury Service Program's definition of "Contractor" and/or that Contractor continues to qualify for an exception to the Program. Attached hereto, Exhibit F, is the required form, "County of Los Angeles Contractor Employee Jury Service

Program Certification Form and Application for Exception", to be completed by the Contractor.

D. Contractor's violation of this subparagraph of the Contract may constitute a material breach of the Contract. In the event of such material breach, County may, in its sole discretion, terminate the Contract and/or bar Contractor from the award of future County contracts for a period of time consistent with the seriousness of the breach.

43. CONTRACTOR RESPONSIBILITY AND DEBARMENT:

A. A responsible Contractor is a Contractor who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity and experience to satisfactorily perform the contract. It is County's policy to conduct business only with responsible contractors.

B. Contractor is hereby notified that, in accordance with Chapter 2.202 of the County Code, if County acquires information concerning the performance of Contractor on this or other contracts, which indicates that Contractor is not responsible, County may, in addition to other remedies provided in the contract, debar Contractor from bidding or proposing on, or being awarded, and/or performing work on County contracts for a specified period of time, which generally will not exceed five (5) years or be permanent if warranted by the circumstances, and terminate any or all existing contracts Contractor may have with County.

C. County may debar Contractor if County's Board of Supervisors finds, in its discretion, that Contractor has done any of the following: (1) violated a term of a contract with County or a nonprofit corporation created by County, (2) committed an act or omission which negatively reflects on Contractor's quality, fitness or capacity to perform a contract with County, any other public entity, or a nonprofit corporation created by County, or engaged in a pattern or practice which negatively reflects on same, (3) committed an act or offense which indicates a lack of business integrity or business honesty, or (4) made or submitted a false claim against County or any other public entity.

D. If there is evidence that Contractor may be subject to debarment, the Department will notify Contractor in writing of the evidence which is the basis for the proposed debarment and will advise Contractor of the scheduled date for a debarment hearing before the Contractor Hearing Board.

E. The Contractor Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. Contractor and/or Contractor's representative shall be given an opportunity to submit evidence at that hearing. After the hearing, the Contractor Hearing Board shall prepare a tentative proposed decision, which shall contain a recommendation regarding whether contractor should

be debarred, and if so, the appropriate length of time of the debarment. Contractor and the Department shall be provided an opportunity to object to the tentative proposed decision prior to its presentation to the Board of Supervisors.

F. After consideration of any objections, or if no objections are submitted, a record of the hearing, the proposed decision and any other recommendation of the Contractor Hearing Board shall be presented to the Board of Supervisors. The Board of Supervisors shall have the right at its sole discretion to modify, deny, or adopt the proposed decision and recommendation of the Hearing Board.

G. If a Contractor has been debarred for a period longer than five (5) years, that Contractor may, after the debarment has been in effect for at least five (5) years, submit a written request for review of the debarment determination to reduce the period of debarment or terminate the debarment. County may, in its discretion, reduce the period of debarment or terminate the debarment if it finds that Contractor has adequately demonstrated one or more of the following: (1) elimination of the grounds for which the debarment was imposed; (2) a bona fide change in ownership or management; (3) material evidence discovered after debarment was imposed; or (4) any other reason that is in the best interests of County.

H. The Contractor Hearing Board will consider a

request for review of a debarment determination only where (1) the Contractor has been debarred for a period longer than five (5) years; (2) the debarment has been in effect for at least five (5) years; and (3) the request is in writing, states one or more of the grounds for reduction of the debarment period or termination of the debarment, and includes supporting documentation. Upon receiving an appropriate request, the Contractor Hearing Board will provide notice of the hearing on the request. At the hearing, the Contractor Hearing Board shall conduct a hearing where evidence on the proposed reduction of debarment period or termination of debarment is presented. This hearing shall be conducted and the request for review decided by the Contractor Hearing Board pursuant to the same procedures as for a debarment hearing.

The Contractor Hearing Board's proposed decision shall contain a recommendation on the request to reduce the period of debarment or terminate the debarment. The Contractor Hearing Board shall present its proposed decision and recommendation to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board

I. These terms shall also apply to any subcontractors of County Contractors.

44. NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT: Contractor shall notify its employees, and shall require each subcontractor to notify its employees, that they may be eligible for the Federal Earned Income Credit under the Federal income tax laws. Such notice shall be provided in accordance with the requirements set forth in Internal Revenue Service Notice 1015.

45. PURCHASING RECYCLED-CONTENT BOND PAPER: Consistent with County's Board of Supervisors policy to reduce the amount of solid waste deposited at County landfills, Contractor agrees to use recycled-content bond paper and paper products to the maximum extent possible in connection with services to be performed by Contractor under this Agreement.

46. CONTRACTOR'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM: Contractor hereby warrants that neither it nor any of its staff members is restricted or excluded from providing services under any health care program funded by the Federal government, directly or indirectly, in whole or in part, and that Contractor will notify Director within thirty (30) calendar days in writing of: (1) any event that would require Contractor or a staff member's mandatory exclusion from participation in a Federally funded health care program; and (2) any exclusionary action taken by any agency of the Federal government against Contractor or one or more staff members barring it or the staff members from participation in a Federally

funded health care program, whether such bar is direct or indirect, or whether such bar is in whole or in part.

Contractor shall indemnify and hold County harmless against any and all loss or damage County may suffer arising from any Federal exclusion of Contractor or its staff members from such participation in a Federally funded health care program.

Failure by Contractor to meet the requirements of this Paragraph shall constitute a material breach of contract upon which County may immediately terminate or suspend this Agreement.

47. NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW: The Contractor shall notify and provide to its employees, and shall require each subcontractor to notify and provide to its employees, a fact sheet regarding the Safely Surrendered Baby Law, its implementation in Los Angeles County, and where and how to safely surrender a baby. The fact sheet is set forth in Exhibit G of this contract and is also available on the Internet at www.babysafela.org for printing purposes.

48. CONTRACTOR'S ACKNOWLEDGMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW: The Contractor acknowledges that the County places a high priority on the implementation of the Safely Surrendered Baby Law. The Contractor understands that it is the County's policy to encourage all County Contractors to voluntarily post the County's "Safely Surrendered Baby Law" poster in a prominent position at the Contractor's place of business. The Contractor will also encourage its Subcontractors, if any, to post this poster in a prominent position in the Subcontractor's

place of business. The County's Department of Children and Family Services will supply the Contractor with the poster to be used.

49. NO PAYMENT FOR SERVICES PROVIDED FOLLOWING EXPIRATION/ TERMINATION OF AGREEMENT: Contractor shall have no claim against County for payment of any money or reimbursement, of any kind whatsoever, for any service provided by Contractor after the expiration or other termination of this Agreement. Should Contractor receive any such payment it shall immediately notify County and shall immediately repay all such funds to County. Payment by County for services rendered after expiration/ termination of this Agreement shall not constitute a waiver of County's right to recover such payment from Contractor. This provision shall survive the expiration or other termination of this Agreement.

50. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION - LOWER TIER COVERED TRANSACTIONS (45 C.F.R. PART 76): Contractor hereby acknowledges that the County is prohibited from contracting with and making sub-awards to parties that are suspended, debarred, ineligible, or excluded from securing federally funded contracts. By executing this Agreement, Contractor certifies that neither it nor any of its owners officers, partners, directors, or principals is currently suspended, debarred, ineligible or excluded from securing federally funded contracts. Further, by executing this Agreement, Contractor certifies that, to its

knowledge, none of its subcontractors, at any tier, or any owner officer, partner, director or other principal of subcontractor is currently suspended, debarred, ineligible, or excluded from securing federally funded contracts. Contractor shall immediately notify County in writing, during the term of this Agreement, should it or any of its subcontractors or any principals of either be suspended, debarred, ineligible, or excluded from securing federally funded contracts. Failure of Contractor to comply with this provision shall constitute a material breach of this Agreement upon which the County may immediately terminate or suspend this Agreement.

51. CONTRACTOR'S CHARITABLE ACTIVITIES COMPLIANCE: The Supervision of Trustees and Fundraisers for Charitable Purposes Act regulates entities receiving or raising charitable contributions. The "Nonprofit Integrity Act of 2004" (SB 1262, Chapter 919) increased Charitable Purposes Act requirements. By requiring Contractors to complete the Charitable Contributions Certification, Exhibit H, the County seeks to ensure that all County contractors which receive or raise charitable contributions comply with California law in order to protect the County and its taxpayers. A Contractor which receives or raises charitable contributions without complying with its obligations under California law commits a material breach subjecting it to either contract termination or debarment proceedings or both (County Code Chapter 2.202).

52. SOLICITATION OF BIDS OR PROPOSALS: Contractor acknowledges that County, prior to expiration or earlier termination of this Agreement, may exercise its right to invite bids or request proposals for the continued provision of the services delivered or contemplated under this Agreement. County and its DHS, shall make the determination to solicit bids or request proposals in accordance with applicable County and DHS policies.

Contractor acknowledges that County may enter into a contract for the future provision of services, based upon the bids or proposals received, with a provider or providers other than Contractor. Further, Contractor acknowledges that it obtains no greater right to be selected through any future invitation for bids or request for proposals by virtue of its present status as Contractor.

53. CONTRACTOR'S CLOSE-OUT OBLIGATIONS:

PPP and PSIP Programs: Contractor shall process all claims submitted for services provided through June 30 for each fiscal year period (July 1 through June 30) that this Agreement is in effect. Contractor shall accept claims received for services provided through June 30 of each fiscal year through October 31, of the next fiscal year. Contractor shall complete the processing of such claims and make every effort to expedite close-out. Contractor shall be reimbursed at the same rates as stated in Exhibits A and B. Contractor also shall complete the processing of all claims for services provided through June 30 as

well as any reports including fiscal year end reports in accordance with the terms and conditions of this Agreement.

MPP Program: Contractor shall process all claims submitted for services provided through November 30 for each program year period (December 1 through November 30) that this Agreement is in effect. Contractor shall accept claims received for services provided through November 30 of each contract year through March 31, of the next program year. Contractor shall complete the processing of such claims and make every effort to expedite close-out. Contractor shall be reimbursed at the same rates as stated in Exhibit C. Contractor also shall complete the processing of all claims for services provided through November 30 as well as any reports including contract year-end reports in accordance with the terms and conditions of this Agreement.

54. RISK MANAGEMENT PROGRAM ORIENTATION: Contractor shall provide Director with a copy of its risk management or loss prevention plan or both. If Contractor does not have a risk management or loss prevention plan, Director will assist Contractor in developing such a plan. Contractor shall also implement a dual notification requirement to ensure that both Contractor's Risk Manager and County are promptly notified of any potential risk exposure arising from the acts or omissions of Contractor's employees hereunder.

In addition, Director shall provide Contractor with appropriate information regarding the DHS' Risk Management Program for distribution to Contractor's employees and agents.

55. NONEXCLUSIVITY: Contractor acknowledges that it is not the exclusive provider to County of claims adjudication services to be provided under this Agreement, that County has, or intends to enter into, contracts with other providers of such services, as applicable, and that County reserves the right to itself perform the services with its own County personnel. During the term of this Agreement, Contractor agrees to provide County with services described in this Agreement.

56. BUDGET REDUCTIONS: In the event that County's Board of Supervisors adopts, in any fiscal year, a County budget which provides for reductions in the salaries and benefits paid to the majority of County employees and imposes similar reductions with respect to County contracts, County reserves the right to reduce its payment obligation correspondingly for that fiscal year and any subsequent fiscal year for services provided by Contractor under this Agreement. County's notice to Contractor regarding said reductions in payment obligation shall be provided within ninety (90) calendar days of the County's Board of Supervisors' approval of such actions. Contractor shall continue to perform all obligations set forth in this Agreement.

57. ALTERATION OF TERMS: The body of this Agreement, together with the Exhibits attached hereto, fully expresses all understandings of the parties concerning all matters covered and shall constitute the total Agreement. No addition to, or alteration of, the terms of this Agreement whether by written or verbal understanding of the parties, their officers, agents, or

employees, shall be valid unless made in the form of a written amendment to this Agreement which is formally approved and executed by the parties.

58. AGREEMENT INCONSISTENCIES: To the extent any conflict exists between the language of the body of this Agreement and the Exhibits attached hereto, then the body of the Agreement and the Exhibits, including their attachments, shall govern and prevail in that order.

59. PRICE GUARANTEE: If Contractor's price declines, or should Contractor, at any time during the term of this Agreement, provide the same services under similar quality and delivery conditions to the State of California or to any county, municipality, or district of the State at prices below those set forth in this Agreement, then such lower prices shall be immediately extended to County.

60. CONSTRUCTION: To the extent there are any rights, duties, obligations, or responsibilities enumerated in the recitals or otherwise in this Agreement, they shall be deemed a part of the operative provisions of this Agreement and are fully binding on the parties.

61. CONTRACTOR'S OFFICES: Contractor's primary business office is located at: 13191 Crossroads Parkway North, Suite 205, City of Industry, California 91746. Contractor's business telephone number is (562) 908-4567 and facsimile/FAX number is (562) 695-6105.

Contractor shall notify County in writing of any change in its primary business or billing address, business telephone number, and/or facsimile/FAX number used in the provisions of services herein, at least ten (10) calendar days prior to the effective date thereof.

If during the term of this Agreement, the corporate or other legal status of Contractor changes, or the name of Contractor changes, then Contractor shall notify County in writing detailing such changes at least thirty (30) calendar days prior to the effective date thereof. For changes in Contractor's corporate or other legal status, the consent of County thereto may be required in accordance with the PROHIBITION AGAINST ASSIGNMENT AND DELEGATION Paragraph, as a condition to this Agreement continuing.

62. NOTICES: Any and all notices required, permitted, or desired to be given hereunder by one party to the other shall be in writing and shall be delivered to the other party personally or by U.S. mail (e.g., U.S. Priority, U.S. Express, certified or registered, return receipt requested) and, as necessary, by facsimile transmission and addressed as follows:

A. Notices to County shall be addressed as follows:

Department of Health Services
Fiscal Services
313 North Figueroa Street
Room 531
Los Angeles, California 90012
Attn: Chief, Fiscal Services

Department of Health Services
Contracts and Grants Division
313 North Figueroa Street, Sixth Floor-East

Los Angeles, California 90012

B. Notices to Contractor shall be addressed as follows:

American Insurance Administrators
A Subsidiary of Management Applied Programming, Inc.
13191 Crossroads Parkway North, Suite 205
City of Industry, California 91746
Attn: Furrokh Dastur, President
Manaz Billimoria, Assistant Vice President

If personally delivered, such notice shall be deemed given upon delivery. If mailed or transmitted by facsimile in accordance with this Paragraph, such notice shall be deemed given as of the date indicated on the facsimile transmission validation or U.S. mail receipt, whichever applies based on mode of transmission used. Either party may change its address for notice purposes by giving prior written notice of such change to the other party in accordance with this Paragraph.

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Agreement to be subscribed by its

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Director of Health Services, and Contractor has caused this Agreement to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
Bruce A. Chernof, M.D.
Director and Chief Medical Officer

AMERICAN INSURANCE ADMINISTRATORS (AIA),
A SUBSIDIARY OF MANAGEMENT APPLIED
PROGRAMMING, INC.
Contractor

By _____
Signature

_____
Printed Name

Title _____

(AFFIX CORPORATE SEAL)

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL
RAYMOND G. FORTNER
County Counsel

APPROVED AS TO CONTRACT
ADMINISTRATION:

Department of Health Services

By _____
Cara O' Neill, Chief
Contracts and Grants Division

EXHIBIT A

PHYSICIAN SERVICES FOR THE INDIGENT PROGRAM (PSIP)
CLAIMS ADJUDICATION SERVICES
STATEMENT OF WORK

1. Definitions:

A. Claims Adjudication Services: Claims adjudication services for the PSIP Program include receipt, review, Medi-Cal coverage identification, PSIP program eligibility determination, provision of preliminary payment listings and final payment information in electronic formats for PSIP claims submitted by physicians for eligible medical services rendered to eligible indigent patients. These services shall be provided according to PSIP policies, procedures, and instructions, which are subject to revision from time to time. For purposes of this Agreement, a claim includes a California Healthcare for Indigents Program ("CHIP") Form, Attachment A-1, a Centers for Medicare and Medicaid Services ("CMS-1500") Form, (formerly known as a Health Care Financing Administration "HCFA 1500" Form), Attachment A-2, and other forms that may be approved and required by the Director.

B. Adjudicated: As used herein, the term "adjudicated" shall apply to claims for which all claims adjudication services have been completed, according to

PSIP policies and procedures, and a payment request or denial has been issued.

C. Denied: As used herein, the term "denied" shall mean a claim or medical procedure that has been adjudicated according to program policies and procedures and found not to be payable.

D. Electronic Claim: As used herein, the term "electronic claim" shall mean a claim that is submitted to the Contractor electronically, on a disk, or some other form of computer media by PSIP physicians for reimbursement of eligible medical services rendered to eligible indigent patients.

E. Contract Year ("CY"): As used herein, the term "contract year" shall mean the twelve (12) month period ending March 31st of the applicable year.

F. Fiscal Year ("FY"): As used herein, the term "fiscal year" shall mean the twelve (12) month period beginning July 1st of a year and ending June 30th of the following year.

G. Hard-Copy Claim: As used herein, the term "hard-copy claim" shall mean a claim that is submitted to Contractor on paper (hard-copy CMS-1500 Form and CHIP

forms) by PSIP physicians for reimbursement of eligible medical services rendered to eligible indigent patients.

H. On-line Access: As used herein, the term "on-line access" shall mean the electronic linkage of Contractor's computerized claims adjudication system to County personal computers (PCs) located at County specified sites (minimum of two (2)) which permit County access to the PSIP Physician Profile Database ("PPD") and PSIP Database.

I. Administrative Appeal: As used herein, the term "Administrative Appeal" shall mean an appeal which 1) involves an issue exclusively related to the PSIP policies and procedures; and 2) does not involve medical issues.

J. Medical Appeal: As used herein, the term "Medical Appeal" shall mean an appeal which involves a medical issue exclusively, and requires the expertise of an appropriate medical professional for appeal resolution.

K. Contractor's System: As used herein, the term "Contractor's System" shall mean any and all computer systems/resources used by Contractor to perform claims adjudication, reporting, etc.

2. Contractor Personnel:

A. Contractor shall designate a Project Manager to lead and coordinate Contractor's claims adjudication services hereunder.

B. Notwithstanding any representation by County regarding the participation of County personnel in any phase of this project, Contractor assumes sole responsibility for the timely accomplishment of all activities described herein.

3. County Personnel: Chief, Fiscal Services, Department of Health Services, shall be designated as County Project Manager (CPM) for activities hereunder, unless otherwise determined by Director. County personnel will be made available to Contractor at the sole-discretion of CPM to provide necessary input and assistance in order to answer questions and provide necessary liaison activities between Contractor and County departments. The word "County" or "Director" shall be deemed to refer to the CPM.

4. Services to Be Provided: Services to be provided immediately upon Board of Supervisors approval include, but shall not be limited to:

A. Contractor shall process hard-copy and electronic claims using an on-line claims processing system and line-item and/or on-line adjudication.

B. Contractor's claims review and processing procedures must include, but shall not be limited to, the following:

1) Sorting claims.

2) Date-stamping (i.e., Month/Date/Year) all claims upon receipt, at the time of the original submission and any subsequent resubmission(s).

3) Reviewing claims for completeness and accuracy based on the PSIP billing instructions provided by County.

4) Rejecting and returning claims which are incomplete or inaccurate and return to the submitting physician within five (5) working days of claim receipt, with a Director approved letter stating the claim deficiencies and the procedures for resubmission, or as otherwise agreed to by Director and Contractor.

5) Entering the claim type (i.e., contract trauma, non-contract emergency, pediatrics, or obstetrics), reason for rejection, claim receipt date, physician's name and tax identification number ("ID#"), patient's name, date of service, and service location on Contractor's system.

6) Entering all claim information and all data elements (Attachments A-3 to A-9) into its system for all complete claims.

7) Flagging all incomplete, erroneous, and duplicate claims.

8) Reflecting line-item denials.

9) Validating procedure and diagnosis codes.

10) Matching Medi-Cal Eligibility History File and Matching Data Elements: Comparing the patient information data provided by County to Contractor against Medi-Cal eligibility history files within ten (10) working days of receipt to identify claims with Medi-Cal coverage.

Contractor shall be responsible to match the following specified Physician claim data elements, if present, against the Medi-Cal eligibility history file:

- Name
- Date of Birth
- Gender
- Social Security Number (SSN), if present
- Date of Service

- Insertion of Medi-Cal Unit Number: Determine unit number, utilizing the eligibility trailer, to be inserted in the fourth position of the Medi-Cal number.

Contractor recognizes that the County format may change from time to time as a result of changing requirements or needs. At County's option, Contractor shall include or delete County specified matching data elements. A successful match shall meet all of the above data elements.

Contractor shall provide an electronic data listing of Medi-Cal-eligible patient information, if requested by the Director. The electronic data transmitted shall include the following information:

- Contractor Log Number
- Patient's:
  - ID/SSN
  - Medi-Cal Number
  - Last Name
  - First Name
  - Middle Initial
  - Address:
    - Street Address
    - City
    - State
    - Zip
  - Gender
  - Date of Birth
  - First Date of Service
  - Filler or Reserve
  - Any other information requested by

Director.

11) Denying Medi-Cal covered claims.

12) Adjudicating non-trauma claims which are not Medi-Cal covered within ten (10) working days of determination that the claim is non Medi-Cal, for a total of twenty (20) working days from the date of receipt.

13) Trauma Patient Summary Number (TPS#) File Format Matching Data Elements: Contractor shall adjudicate trauma claims by comparing the PSIP trauma claims, provided by County's Emergency Medical Services Agency (EMS) to Contractor, with the TPS# hospital patient data file within ten (10) working days following the TPS# match to identify eligible claims.

Contractor shall be responsible to electronically match the following specified PSIP trauma claims data elements as provided by County:

- Computer Media: Electronic transmission from Lancet
- Encoding Format: Flat ASCII file
- Matching Data Elements:
  - TPS# (8 digit alphanumeric code)
  - Hospital Code (4 digit)
  - Patient Name
  - Payor Code (or description).

- Date of Service.

Contractor recognizes that the County format may change from time to time as a result of changing requirements or needs. At County's option, Contractor shall include or delete County specified matching data elements.

14) Automatically/manually assigning a unique claim number.

15) Performing audits and quality assurance sampling.

16) Providing claims reporting.

17) Performing other claim edits, as may be required by Director, from time to time.

18) Accepting amounts from the Director to be paid for each claim type, fund, and organization code, and being able to suspend any unprocessed claims which are not to be paid in the current payment cycle, and include any suspended claims in the next payment cycle in the order of the date received.

19) Preparing Remittance Advices ("RA"), pursuant to Attachment A-10 "Sample Remittance Advice Specifications", for claims adjudicated for payment and those denied due to Medi-Cal coverage, including

the applicable Medi-Cal numbers, and electronically transmitting via email the RAs on a bi-weekly basis to County site.

20) Slowing or ceasing claims adjudication services, upon Director's request, in order not to exceed PSIP funding limits.

21) Providing an electronic warrant file to County's Auditor Controller, which will group the claims by funds, including an electronic copy of the warrant register, identifying the amounts from the following funds:

1) Physicians Services Account - BW7 -

2) Measure B - BW9, and any other available funds.

22) Processing an updated copy of the electronic warrant file, including the issue date and warrant number provided by the County, on the same day if received by no later than 10:00 a.m., and by the next business day if not, using high speed, secure electronic media, as specified and agreed to by Director, to transmit and receive the electronic warrant files and add them to the RA before it is printed.

23) Providing mailing services, i.e, addressing, stuffing, sealing, and mailing RAs, including the RAs for denied claims, to PSIP physicians (County will reimburse Contractor $0.015 per claim and the postage costs associated with the mailing). On the same day of mailings Contractor shall electronically transmit, via email, the RA report to DHS Fiscal Services.

24) Making all Official County Fee Schedule ("OCFS") modifications to its claims adjudication programs necessary to process and adjudicate all PSIP claims and comply with this Exhibit, the Attachments, and modifications thereto, at no additional cost to County.

25) Recouping funds or reducing a physician's future claim payments (e.g., if the claim has been erroneously paid or if the physician receives a payment from the patient or third-party payor, after the claim has been paid), as instructed by Director, via a Director approved letter with recoupment payments to be sent directly to County along with a copy of the RA to County, or if the RA is not available, advising physicians to provide the following information along with the refund check:

- patient's name,
- patient's social security number,
- date of service,
- amount of patient's refund,
- physician's tax ID number, and
- physician's license number;
- adjusting the physician account balances accordingly when a refund is received and,
- at Director's discretion, providing the Director or his designee(s) with access to Contractor's system to either cancel claim in full or indicate partial refund adjustment.

C. Establish and maintain a unique PPD Database and PSIP Database for each FY.

1) The PPD shall incorporate all data elements described in Attachment A-11, Contract Physician Profile Record Layout. Contractor shall regularly update the PPD to ensure that physician information, as requested on the Physician Enrollment Form, is readily available to Director. The PPD shall be based on Attachment A-5, Physician Enrollment Form and Attachment A-3, Conditions of Participation Agreement,

which each participating physician submits upon entry into PSIP and updates each FY or more often as necessary. The Physician Enrollment Form shall serve as written notice from the physician that information may be entered into the Database.

2) The PSIP Database incorporates all data elements necessary for all PSIP related work, including, but not limited to, preparing reports, providing Medically Indigent Care Reporting System ("MICRS") data, and as otherwise described within this Agreement and related Attachments.

D. Provide MICRS data according to County specifications, as specified in Attachments:

- A-12: MICRS Statement of Work
- A-13: Record Layout/MICRS Dictionary
- A-14: MICRS Code Tables

E. Review, analyze, and research all Administrative Appeal issues and recommend County action based on PSIP policies and procedures. Contractor shall regularly attend scheduled meetings of the County's Physician Reimbursement Advisory Committee ("PRAC"). Upon Director's approval, Contractor shall refer all Medical Appeals to the Physician Appeals Board. Contractor shall prepare appeal summaries

and notifications to physicians of appeal disposition. Responses to claim appeals shall be issued by Contractor with a Director approved letter, stating the appeal disposition and an updated RA, if appropriate. All claim appeal response letters are to be approved by Director and mailed by Contractor.

F. Provide system connectivity to two (2) County specified work stations to be designated by County's Project Manager. Contractor shall also provide the capability for County's personal computers, linked to Contractor's system, to have inquiry capability and to request manipulation of any and all data elements in the PSIP Database and PPD and download as an ASCII, comma delimited, or Microsoft Excel file, at the Director's election, the results and/or summary of such manipulation onto County's personal computers. If requested by Director, Contractor shall provide three (3) days of formal training for County on-line users and assistance as necessary for each year during the term of the Agreement. Director shall select the two (2) persons for which training will be provided.

In the event that special hardware is necessary in order to access the Contractor's system or to link County's

two (2) work stations to Contractor's system, Contractor shall provide such hardware (including software) for County's use. Contractor shall install and maintain all hardware (including software) provided to County herein.

G. Develop, maintain, and provide detailed written instructions for physician submission of claims, including electronic, as approved by Director. As needed or requested by Director, Contractor shall have workshops for County staff, physicians, and physician billing groups to support claim submission, both electronic and manual.

H. Provide and manage a telephone hot line for physicians to inquire on the status of claims. Questions regarding the PSIP program or policy issues are to be referred to Director. Upon physician request, Contractor will send out the Director's approved billing instructions. The hot line must be staffed from 8:00 a.m. to 4:30 p.m., Pacific Standard Time, Monday through Friday, except County holidays. At a minimum, the hot line must have voice mail or other message capabilities to receive calls during non-operation hours. Except for holidays and weekends, calls must be returned within 24 hours. A log of all calls must be maintained and shall include, but shall not be limited to:

- physician's name,
- billing group name,
- caller's name,
- claim number,
- date and time of call,
- a brief summary of the purpose and disposition of the call, and
- name of person who took the call.

This log shall be made available to Director upon request at all reasonable times, for review and for photocopying.

I. Prepare written materials for review and approval by Director prior to distribution (addressing, stuffing, and sealing envelopes) to physicians and deliver same to Director.

J. Develop and maintain a Backup System consisting of an electronic copy of the PSIP Database, PPD, and all other related data on CD or on other County specified computer media off-site. The PSIP Database shall be backed up on a daily basis; the PPD shall be backed up regularly. In the event that Contractor's system becomes inoperative, Director and Contractor shall mutually agree on a

reasonable time frame to resume processing physician claims.

K. Provide Online Access to all active FY physician claims until year-end reconciliation has been completed and determined closed by County.

5. Additional Requirements: In performing the services hereinabove, Contractor shall:

A. Perform at all times in a professional and businesslike manner when assisting physicians and answering physician's questions.

B. Employ industry standards to ensure appropriate payments to physicians under the PSIP program.

C. Respect the confidential nature of all information with regard to physician patient records and PSIP financial records. Contractor acknowledges the confidentiality of all physician patient data and, therefore, shall obtain/extract only that information needed to meet claims processing and adjudication requirements. All such collected information shall become the property of County upon the termination of this Agreement, unless otherwise agreed to by Director.

D. Prepare all correspondence to physicians in a professional and businesslike manner; no correspondence may

be hand written and all correspondence to physicians must be approved by Director in writing prior to sending, unless otherwise directed by County's Project Manager.

6. Optional Services: The County may exercise its option to require the Contractor to perform specific optional services. County may require the Contractor to provide Medicare eligibility matching and/or the services of an Audit Nurse Specialist, who will work with County staff to ensure the medical codes listed on the claims are appropriate, no more than two 8-hour days per month. The nurse will be required to have knowledge of medical and financial coding.

7. Access to information: In order for Contractor to provide the services described in this Exhibit, Director shall provide Contractor necessary and pertinent PSIP information, including operational/administrative records, and statistics.

Contractor shall return all the material provided by Director, upon his/her request, including but not limited to, PSIP Database data files, PPD data files, physician patient records/data, PSIP financial records, all information incidental to contract administration, all completed work, all PSIP and MICRS data, in the same condition and sequence in which received within thirty (30) calendar days from date of request.

8. Reports: Contractor shall provide financial, management, and ad-hoc reports, as requested by CPM. Contractor shall submit a weekly report listing all claims received in-house, and claims denied, rejected, Medi-Cal covered, and adjudicated by FY or CY of service, as requested by CPM. Claim management reports shall be submitted to CPM and shall include, but not be limited to, the following:

- Monthly reports with amounts of various payment categories and a monthly report that reflects weekly claim activity;
- Claims submitted and paid by individual physicians;
- Summary Reports (type/payment/status of claim);
- Claims by month or services or payment;
- Claims by physician tax ID#;
- Claims by physician license number;
- Claims reporting by procedure, diagnosis, and physician specialty by tax ID# and license number;
- Statistics and special reporting;
- RA Reports; and
- Ad-hoc reports, such as top 100 surgical codes, top 100 procedure codes, reports by physician specialty, and reports by hospital code to be provided within five (5) working days of written request.

The monthly report shall include weekly claim activity and shall reflect the number of rejected, denied, denied due to Medi-Cal coverage, and adjudicated claims, as well as number of claims received in-house but which have not been processed and/or adjudicated. As each month of claims processing services is completed, the monthly report describing that month's claim activity is to be submitted to CPM within ten (10) working days of the end of that completed month. Contractor shall provide analysis and interpretation of reports, as needed.

Contractor shall prepare all the necessary reconciliation reports (monthly, quarterly, biannually, yearly, or as otherwise requested by CPM) for each FY, and make any and all necessary payment and/or refund adjustments. Contractor shall re-adjudicate PSIP claims (due to changes in reimbursement rates by a percentage to be determined), as may be deemed necessary by CPM, and County shall pay for re-adjudicating the claims.

If at any time re-adjudication is necessary due to an error of the Contractor, then no additional per-claim cost shall be due to Contractor.

Director and Contractor shall mutually work to ensure that County's records and Contractor's PSIP database are fully reconciled. Each FY shall be fully and completely reconciled as determined by Director.

9. Records and Audits: Subject to the conditions and terms set forth in the body of Agreement, Contractor agrees to make all billing and eligibility records available upon request, during normal business hours, to Director and authorized State and federal representatives, for inspection, audit, and copying. Contractor may use microfilm or other media for purposes of maintaining hard copy claim files. Contractor shall provide to Director such material in County specified electronic data format and on specified computer media.

Such records shall be retained in accordance with the RECORDS AND AUDITS Paragraph of the ADDITIONAL PROVISIONS.

10. Quality Improvement: Contractor shall provide to Director a written description of the quality control and claim management procedures employed by Contractor to process and adjudicate PSIP claims.

Quality control and claim management procedures shall include, but are not limited to, appropriate claim edits to ensure payment accuracy, non-payment of out-of-County claims, flagging of duplicate billings and overpayments which require Contractor to recoup funds or to reduce a physician's future claim payments, and audit trails to substantiate all adjudicated claim payment authorizations.

Director may periodically sample Contractor's work and request Contractor to provide an audit of its internal claims processing/adjudication procedures in order to determine the accuracy of Contractor's claims processing/adjudication practices. Should any work be inaccurate, as determined by Director, Director will notify Contractor within a reasonable period of time of such findings. Contractor shall correct any and all inaccuracies within ten (10) working days of receipt of notice of any errors and such correction shall be at no additional cost to County. In the event that Director finds that the errors have not been corrected by Contractor, the cycle of corrective action by Contractor and re-sampling by Director may, at Director's sole discretion, be repeated. Director will notify Contractor within a reasonable period of time of the re-sampling results.

11. Payment: Contractor shall bill County in arrears. The sole compensation to Contractor for services provided hereunder shall be as follows:

A. Contract Trauma, Non-Contract Emergency, Pediatrics, or Obstetrics:

1) Set-up Fees: Contractor shall not receive a set-up fee.

2) Systems Modifications: Contractor shall receive a fee of $80 per programming hour or prorated portion thereof for periods less than one hour for revised or new programming requested by Director, the rate and process which the parties will use as described below:

a) Contractor shall submit to Director a quotation in writing for the projected work, including an estimated number of programmer hours for completion of the programming task.

b) Director shall determine the credibility of the estimate submitted by Contractor and, if necessary, revise the estimated number of hours requested for performing the programming task. Director shall apprise Contractor in writing of County's acceptance of the quotation or of the revised estimate within ten (10) calendar days of the Director's receipt of the quotation.

c) Contractor shall, upon completion of the work, submit an invoice to County with the actual number of hours that was required to complete the programming Task, not to exceed,

however, the number of hours for completion for the task as approved by Director in accordance with Subparagraph (2) above, and prepare and keep detailed records of staff work and time spent on any programming task hereunder, and shall make them available for audit and photocopying upon request by County representative pursuant to Paragraph 9 (Records and Audits) of this Exhibit.

3) Adjudication Fees:

a) Contractor shall receive the following fees for each manual (hard-copy) and electronic Service claim adjudicated during a contract year that results in payment to a PSIP Physician by the County or a denial due to Medi-Cal coverage:

	Manual	Electronic
Year 1	$2.85	$1.50
Year 2	$3.00	$1.60
Year 3	$3.00	$1.60
Year 4	$3.15	$1.65
Year 5	$3.15	$1.65

B. Mailing Services: County will reimburse Contractor $0.015 per claim for the actual cost of postage associated with the mailing described in Paragraph 4,

Services To Be Provided, Subparagraph B, 23 of this Exhibit.

C. Eligibility Matching: Contractor shall receive a fee of $2,000 per month to perform Medi-Cal eligibility matching.

D. TPS Number Matching: Contractor shall not receive a fee for TPS matching.

E. Printing Services: Contractor shall receive reimbursement for their costs of printing services (e.g. physician enrollment packages, PSIP newsletters, etc.).

F. Optional Services

1) Audit Nurse Specialist: Contractor shall receive a fee of $40 per hour or prorated portion thereof for periods less than one hour for the services provided by an Audit Nurse Specialist, as described in Paragraph 6, Optional Requirements.

2) Medicare Eligibility Matching: Contractor shall receive a fee of $1,500 per month to perform Medicare eligibility matching.

3) MICRS Reporting: Contractor shall not receive a fee for MICRS Reporting, as described in Attachment A-3, Conditions of Participant Agreement.

G. Corrections: Corrections of any and all claims due to Contractor's errors, as determined by County, shall be performed at no cost to County. County may periodically sample the work to determine the accuracy of processing. Should any work be inaccurate, as determined by County, Contractor shall promptly correct all inaccurate or unacceptable work to conform to the requirements of this Exhibit, in accordance with Paragraph 10, Quality Improvement, and the Attachments, or as otherwise determined by County. County may withhold fifteen percent (15%) of Contractor's invoice amount until all claims processing services work is acceptable to County. County will provide written notice to Contractor within a reasonable period of time of any claims processing services work which is not acceptable to County.

H. Specified Time Period: County shall be liable to Contractor with regard to amounts payable to Contractor for services performed hereunder that fall within a contract time period specified in the Agreement.

I. Invoices: Contractor shall submit a monthly invoice, in arrears, showing all claims processed and adjudicated and amount of Medi-Cal eligible claims and the costs for mailing services for the previous month of

service. County shall pay all invoices within thirty (30) calendar days from receipt of complete and correct billing, as determined by CPM. County shall only reimburse Contractor for each adjudicated claim that result in payment to PSIP Physician by Director or Denied Medi-Cal eligible claim.

In the event that Director requires Contractor to re-adjudicate any and all claims due to the year end reconciliation process, County shall pay only for the programming cost to calculate the adjusted payment amount for each claim. County shall not pay the negotiated processing and adjudication fee per claim.

If at any time re-adjudication is necessary due to an error of the Contractor, then no additional per-claim cost shall be due to Contractor.

J. Accuracy of Work: Corrections of any and all claims due to Contractor's errors, as determined by Director, shall be performed at no cost to County. County may periodically sample the work to determine the accuracy of processing. County will provide written notice to Contractor within a reasonable period of time of any claims processing services work which is not acceptable to County. Contractor shall promptly correct all inaccurate or

unacceptable work to conform to the requirements of this Exhibit and Attachments at no additional cost to County. County may withhold fifteen percent (15%) of Contractor's invoice amount until all claims processing services work is acceptable to County.

County of Los Angeles • Department of Health Services

ATTACHMENT

NON-COUNTY HOSPITALS

CALIFORNIA HEALTHCARE FOR INDIGENTS PROGRAM (CHIP)

FOF EMS USE ONLY
TRAUMA YES ☐ NO ☐

PATIENT INFORMATION

COMPLETE ENTIRE CLAIM AND SUBMIT WITH UB-92

01. TPS #

02. SOCIAL SECURITY NUMBER:

03. PATIENT'S NAME: LAST FIRST MIDDLE INITIAL

(1) IF MINOR. PARENT / GUARDIAN: LAST FIRST

04. PLACE OF BIRTH: CITY STATE COUNTRY

05. MOTHERS MAIDEN NAME:

06. ETHNICITY
☐ (1) WHITE
☐ (2) BLACK
☐ (3) ASIAN / PACIFIC ISLANDER
☐ (4) NATIVE AMERICAN / ESKIMO / ALEUT
☐ (5) HISPANIC
☐ (6) FILIPINO
☐ (7) OTHER

07. EMPLOYMENT TYPE:
☐ (0) UNEMPLOYED
☐ (1) FARM / FORESTRY / FISHING
☐ (2) LABORERS / HELPERS / CRAFTS / INSPECTION/ REPAIR / PRODUCTION / TRANSPORTATION
☐ (3) SALES / SERVICES
☐ (4) EXECUTIVE / ADMINISTRATIVE / MANAGERIAL / PROFESSIONAL TECHNICAL RELATED SUPPORT
☐ (5) OTHER

08. MONTHLY INCOME: $

09. FAMILY SIZE (COUNT PATIENT AS 1):

10. SOURCE OF INCOME:
☐ (0) NONE
☐ (1) GENERAL RELIEF
☐ (2) WAGES
☐ (3) SELF-EMPLOYED
☐ (4) DISABILITY
☐ (5) RETIREMENT
☐ (6) OTHER: ,e.g., UNEMPLOYMENT / VA BENEFITS / INTEREST / DIVIDENDS / RENT / CHILD SUPPORT / ALIMONY, ETC.

PATIENT INFORMATION VERIFICATION

IF UNABLE TO OBTAIN PATIENT INFORMATION, HOSPITAL REPRESENTATIVE MUST GIVE REASON (S) WHY INFORMATION WAS NOT OBTAINED AND MUST SIGN INDICATING EVEYRY ATTEMPT WAS MADE

REASON (S) (20)

SIGNATURE: (21)

HOSPITAL SERVICES

11. HOSPITAL: CODE: PROVIDER ID:

12. HOSPITAL FUND
☐ (1) FORMULA
☐ (2) CONTRACT TRAUMA

13. SERVICE SETTING (1 SETTING ONLY)
☐ (1) EMERGENCY DEPARTMENT
☐ a. NON-EMERGENCY VISIT
☐ b. EMERGENCY VISIT
☐ (2) INPATIENT
☐ (3) OUTPATIENT / CLINIC VISIT

14. DATE OF SERVICE / ADMISSION (MO/DY/YR):

15. DISPOSITION
☐ (1) DISCHARGE (INPATIENT ONLY) DATE
☐ (2) TRANSFER TO COUNTY HOSPITAL DATE
☐ (3) TRANSFER TO NON-COUNTY HOSPITAL DATE
☐ (4) RELEASE (EMERG DEPT. / OUTPATIENT ONLY) DATE
☐ (5) DEATH DATE
☐ (6) STILL HOSPITALIZED

16. PAYERS SPECIFY NAME AMOUNT PAID

17. DATE BILLED TO COUNTY:

PRIVATE INSURANCE $

18. CHARGES: $

OTHER: $

FOR QUESTIONS REGARDING CLAIM:

FOR COUNTY USE ONLY AMOUNT DISBURSED $

19. CONTACT PERSON: TELEPHONE NO: ( )

CHIP FORM REVISED 6/03

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM | DD | YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM | DD | YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD | YY FROM TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY FROM TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM

FISCAL YEAR 2006/07
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for emergency, obstetric, or pediatric services provided by him/her to patients who do not have health insurance coverage for emergency services and care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Physician acknowledges receipt of a copy of the "Physician Services for Indigents Program (PSIP) Billing Procedures" (hereinafter "Billing Procedures"), promulgated by the County of Los Angeles, Department of Health Services, for fiscal year 2006/07.

Physician certifies that claims for emergency services shall only be submitted for emergency services provided on the calendar day on which emergency services are first provided and on the immediately following two calendar days (except for eligible trauma patients provided services at County contract trauma hospitals through a separate program, the Trauma Physician Services Program).

Physician agrees that all obligations and conditions stated in the Billing Procedures will be observed by him/her, including, but not limited to, the proper refunding of monies to the County when patient or third-party payments are made after reimbursement under this claiming process has been received; the cessation of current, and waiver of future, collection efforts upon receipt of payment; and the preparation, maintenance, and retention of service and finance records, including their availability for audit. Physician affirms that for all claims submitted, reasonable efforts to identify third-party payers have been made, no third-party payers have been discovered, and no payment has been received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the PSIP. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the PSIP. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

Physician expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to conditions defined in the Billing Requirements, including, but not limited to, (1) availability of monies in the PSIP, (2) priority of claim receipt, and (3) audit and adjustments. In accordance with instructions in the Billing Procedures, Physician agrees to submit required documents for claims, and provide other patient data as may be required by the County.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

TYPED/PRINTED NAME OF PHYSICIAN	TAX ID NUMBER
PRIMARY SPECIALTY OF PHYSICIAN	SIGNATURE OF PHYSICIAN
STATE LICENSE NUMBER	DATE

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

FISCAL YEAR 2006/07
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)
P.O. Box 2340
Bassett, CA 91746-0340

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for trauma services provided by him/her at a County contract trauma hospital to trauma patients who do not have health insurance coverage for emergency services and care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Physician acknowledges receipt of a copy of the "Trauma Physician Services Program Billing Procedures" (hereinafter "Billing Procedures"), promulgated by the County of Los Angeles, Department of Health Services, for fiscal year 2006/07, the terms and conditions of which are incorporated herein by reference.

Physician agrees that all obligations and conditions stated in the Billing Procedures will be observed by him/her, including, but not limited to, the proper refunding of monies to the County when patient or third-party payments are made after reimbursement under this claiming process has been received; the cessation of current, and waiver of future, collection efforts upon receipt of payment; and the preparation, maintenance, and retention of service and finance records, including their availability for audit. Physician affirms that for all claims submitted, reasonable efforts to identify third-party payers have been made, no third-party payers have been discovered, and no payment has been received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the Trauma Physician Services Program. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the or Trauma Physician Services Program. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

Physician expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to conditions defined in the Billing Procedures, including, but not limited to, (1) availability of monies, (2) priority of claim receipt, and (3) audit and adjustments. In accordance with instructions in the Billing Procedures, Physician agrees to submit required documents for claims, and provide other patient data as may be required by the County.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

TYPED/PRINTED NAME OF PHYSICIAN	TAX ID NUMBER
PRIMARY SPECIALTY OF PHYSICIAN	SIGNATURE OF PHYSICIAN
STATE LICENSE NUMBER	DATE

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAM

PROGRAM ENROLLMENT PROVIDER FORM FISCAL YEAR 2006/07

Completion of Enrollment Form is required annually by each physician

Physician Name: _____
(Last Name) (First Name) (M.I.)

Address: _____ City: _____ Zip Code: _____

Telephone No.: (____) _____ Contact Person: _____

E-mail Address: _____

Primary Specialty: _____ State License Number: _____

U.P.I.N.: _____ Payee Tax I.D.#: _____

Payee Address: _____ City: _____ State: _____ Zip Code _____

Physician/Group name must match IRS Tax ID Number

IF PAYEE IS A PHYSICIAN GROUP, COMPLETE GROUP INFORMATION BELOW:

Group Name: _____

IF USING A BILLING COMPANY, COMPLETE BILLING COMPANY INFORMATION BELOW:

Company Name: _____ E Mail Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: ( ) _____ Contact Person: _____

LIST ALL HOSPITALS WHERE MEDICAL SERVICES ARE PROVIDED WITHIN LOS ANGELES COUNTY

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

If information on this form changes in any way, a new provider application must be submitted with the corrected information. This application must be completed by each physician providing services claimed under this program.

As a condition of claiming reimbursement under the Physician Services for Indigents program and/or the Trauma Physician Services Program, I certify that the above information is true, and complete to the best of my knowledge.

_____ _____
SIGNATURE OF PHYSICIAN DATE

IMPORTANT: For prompt processing, return this form as soon as possible to:

AMERICAN INSURANCE ADMINISTRATORS
P.O. BOX 2340
Bassett, CA 91746-0340

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAMS

PHYSICIAN REIMBURSEMENT POLICIES

• • • Revised for Fiscal Year 2006/07 • • •

I. POLICY STATEMENT

THE PURPOSE OF THIS POLICY IS TO ENSURE THE COUNTY'S CONFORMANCE WITH STATUTORY AND REGULATORY REQUIREMENTS, AND TO ADDRESS PRIORITIES OF THE HEALTH CARE SYSTEM WHICH ARE CRITICAL TO PROVIDING FOR THE MEDICAL NEEDS OF THE INDIGENT POPULATION, WITHIN THE LEVEL OF AVAILABLE FUNDS.

II. GENERAL RULES

A. Official County Fee Schedule: The Official County Fee Schedule is used to determine reimbursement rates for eligible physician claims. The Official County Fee Schedule, which establishes rates of reimbursement deemed appropriate by the County utilizes the most current Physicians' Current Procedural Terminology ("CPT-4") codes which coincides with the current Resource Based Relative Values Scale ("RBRVS") unit values and a County-determined weighted average conversion factor. The conversion factor for all medical procedures except anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value. Reimbursement is also limited to the policy parameters contained herein.

B. Eligible Period: Reimbursement shall be for emergency medical services provided on the calendar day on which emergency services are first provided and on the immediately following two calendar days. EXCEPTION: Trauma physicians providing trauma services at County contract trauma hospitals may bill for trauma physician services provided beyond this period.

C. Nonemergent Pediatric and OB Services: Reimbursement may be provided for nonemergency, medically necessary services **ONLY IF** they are provided to a patient who is under 21 years of age (a pediatric patient) or to a pregnant woman from time of conception until ninety (90) calendar days following the end of the month in which the pregnancy ends (an obstetric patient).

D. Medi-Cal/Medicare Exclusions:

1. Procedures which are not covered in the Medi-Cal Program's Schedule of Maximum Allowances ("SMA") are excluded from reimbursement.

2. Procedures which are covered in Medi-Cal's SMA but require a Treatment Authorization Request ("TAR") are excluded from reimbursement; however, will considered upon appeal and/or provision of applicable operative and/or pathology reports.

3. Claims determined to be Medi-Cal eligible will be denied.

E. Screening Exams: Payment will be made for emergency department medical screening examinations required by law to determine whether an emergency condition exists.

F. Assistant Surgeons: Reimbursement for assistant surgeons will be at a rate of 16% of the primary surgeon's fee.

G. Pediatric Hospitalization Over Five Days: All claims for pediatric patients hospitalized in excess of five calendar days must be accompanied by a statement from the hospital indicating sources the hospital utilized for reimbursement.

H. Multiple Surgery Procedure Codes: Adjudication of claims involving multiple surgery procedure codes performed in an inpatient operating room requires submission of operative reports. No more than five (5) Procedure Codes shall be paid as follows: 100% for 1st Procedure and 50% for the 2nd through 5th Procedures.

I. Nurse Practitioner and Physician's Assistant Services: Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician's assistants in California.

III. INELIGIBLE CLAIMS

A. Office Visits: Procedures performed in a physician's office will be denied unless documentation is provided to show that an eligible service was provided to either a pediatric or an obstetric patient. If a claim is made for services provided to an obstetric patient, the expected date of delivery ("EDD") must be included on the CHIP Form (Item #20). An obstetric claim submitted without the EDD will be rejected.

B. Duplicate Procedures: Claims which include duplicate procedures provided to the same patient for the same episode of care are generally excluded from reimbursement. This does not apply for Evaluation & Management codes billed by separate physicians.

C. Unlisted Procedures: Procedures which are not listed in the Official County Fee Schedule are excluded from reimbursement.

D. Non-physician Procedures: Procedures commonly not performed by a physician will be denied (e.g., venipuncture). Claims will be reviewed and considered on appeal only.

E. Insurance Rejections: Claims for patients with potential insurance or other third-party payer coverage will be denied unless a notice of rejection from the insurance company or other third-party payer is provided to the County. The rejection notice should indicate either (1) the patient is not a covered beneficiary or (2) the term of coverage expired prior to the date of the claimed service. If insurance or other third-party coverage has been denied for other reasons, e.g., the deductible has not been met, the type or scope of service has been classified as a nonemergency, or other similar issues denying insurance coverage, the claim will be denied. Where limited insurance policies have been exhausted by hospital billings, physician claims will be reviewed and considered on appeal.

IV. EXCLUSIONS

A. Radiology/Nuclear Medicine (Codes 70002 - 79499): Reimbursement for radiology codes will be limited to "Wet" or "Stat" readings performed while the patient is in the emergency department or other eligible site. Additionally, payment will only be made for the first radiology claim received by the County per patient per episode of care. Subsequent radiology claims for the same patient/episode will be denied.

B. EKG (Code 93010): Reimbursement for EKG codes will only be made for the first EKG claim received by the County per patient per episode of care. Subsequent EKG claims for the same patient/episode will be denied.

C. Pathology (Codes 80104 - 89999): Reimbursement for pathology codes will be limited to codes 86077, 86078, and 86079. Additionally, codes 88329, 88331, and 88332 will be reimbursed only if the pathologist is on site and pathology services are requested by the surgeon.

D. Surgery (Codes 10000 - 69979): There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).

E. Anesthesia: There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).

F. Modifiers: Reimbursement is excluded for all modifiers except radiology.

G. Prior Dx Codes: Reimbursement will no longer be made for wound checks and suture removal.

H. Critical Care (Codes 99291 and 99292): Reimbursement will not be made on critical care codes after the first 24 hours of service.

I. Newborn Care (Inpatient Code 99431 and Emergency Department Code 99283): Reimbursement will only be made once for the same recipient by any provider and only if accompanied by a Medi-Cal denial. V30 through V30.2 codes are reimbursable only if a copy of Medi-Cal denial is provided.

V. ADDITIONAL EXCLUSIONS

Upon approval of the Board of Supervisors, the County may revise the Physician Reimbursement Polices from time to time as necessary or appropriate.

VI. APPEALS

Appeals for claims rejected or denied may be submitted to the Physician Reimbursement Advisory Committee ("PRAC"), a committee of physicians selected by Hospital Council of Southern California and by the Los Angeles County Medical Association. Appeals shall include the CHIP Form, HCFA-1500, operative reports, if applicable, and supporting documents as needed. Appeals shall be mailed to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: APPEALS UNIT

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COUNTY OF LOS ANGELES ● DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM

BILLING PROCEDURES

● ● ● Revised for Fiscal Year 2006/07 ● ● ●

I. INTRODUCTION

Pursuant to provisions of the State of California Welfare and Institutions code ("WIC"), sections 16950, et seq., and Health and Safety Code ("HSC"), sections 1797.98a, et seq., a Physician Services for Indigents Program ("PSIP") has been established by the County of Los Angeles ("County") to provide reimbursement to private physicians ("Physician") for certain professional services that have been rendered in Los Angeles County to eligible indigent patients. Professional physician services herein referred to are limited to emergency services as defined in WIC, section 16953; obstetric services as defined in WIC, section 16905.5; and pediatric services as defined in WIC, section 16907.5.

Professional physician services which can be reimbursed under this claiming process are additionally restricted as prescribed by the County, with such restrictions subject to revision from time to time. Current County physician reimbursement restrictions are set forth in "Department of Health Services Physician Reimbursement Policies, Revised for Fiscal Year 2006/07", attached as Exhibit "A" hereto and incorporated herein by reference. The County has discretion to revise such policies from time to time as deemed necessary or appropriate and if approved by the Board of Supervisors.

In no event may this claiming process be used by Physician if his/her services are included in whole or in part in hospital or physician services claimed by a hospital or by Physician under a separate formal contract with County. Nor may this claiming process be used if Physician has previously billed County for his/her emergency, obstetric, or pediatric services under any other claiming process established by County.

This document defines the procedures which must be followed by Physician in seeking reimbursement under this Program. Submission of a claim by Physician under these procedures establishes (1) a contractual relationship between the County and Physician covering the services provided and (2) signifies Physician's acceptance of all terms and conditions herein.

These claiming procedures are effective July 1, 2006; are only valid for covered services to the extent that monies are available therefor; and are subject to revisions as required by State laws and regulations and County requirements. This claiming process may not be used by a physician if he or she is an employee of a County hospital.

II. PHYSICIAN ELIGIBILITY

A. Physician must complete a current fiscal year Physician Services for Indigents Program "Conditions of Participation Agreement" and "Program Enrollment Provider Form" and provide them to the County's Emergency Medical Services ("EMS") Agency in care of the contracted Claims Adjudicator (see address on page 5). Physician claims will not be accepted if said Agreement is not on file with the EMS Agency.

B. Physicians who provide emergency services to eligible patients in a Los Angeles County (1) basic or comprehensive emergency department of a licensed general acute care hospital, (2) standby emergency department that was in existence on January 1, 1989 in a small and rural hospital as defined in HSC, section 124840, or (3) site approved by the County prior to January 1, 1990, as a paramedic receiving station for the treatment of patients with emergency medical conditions, may submit claims hereunder, if all the following conditions are met:

1. Emergency services are provided in person, on site, and in an eligible service setting.

2. Emergency services are provided on the calendar day on which emergency services are first provided, and on the immediately following two calendar days.

Notwithstanding paragraph II B 2 above, if it is necessary to transfer the patient to a second facility that provides for a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided to the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days.

Physician employees of a County hospital are not, however, eligible for reimbursement under this claiming process.

C. Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.

D. Physicians who provide medically necessary obstetric or pediatric services to an eligible patient in a hospital, emergency department, or private office located in Los Angeles County, other than a hospital, emergency department or office owned or operated by the County, may submit a claim hereunder. However, no physician

may submit a claim for services provided in a primary care clinic which receives funding under provisions of Chapter 1331, Statutes of 1989.

E. An emergency physician and surgeon or an emergency physician group with a gross billings arrangement with a hospital located in Los Angeles County shall be entitled to receive reimbursement for services provided in that hospital, if all of the following conditions are met:

1. The services are provided in a basic or comprehensive general acute care hospital emergency department.

2. The physician and surgeon is not an employee of the hospital.

3. All provisions of Section III of these Billing Procedures are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

4. Reimbursement is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon or an emergency physician group.

For the purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays a percentage of the emergency physician and surgeon's or group's billings for all patients.

III. PATIENT ELIGIBILITY/BILLING EFFORTS

Patients covered by this claiming process are only those who do not have health insurance coverage for emergency services and care, cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, including Medi-Cal, but with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

During the time prior to submission of the bill to the County, Physician must have made reasonable efforts to obtain reimbursement and not received payment for any portion of the amount billed. For purposes of this claiming process, reimbursement for unpaid physician billings shall be limited to the following:

(a) patients for whom Physician has conducted reasonable inquiry to determine if there is a responsible private or public third-party source of payment; and

(b) patients for whom Physician has billed all possible payment sources, but has not received reimbursement for any portion of the amount billed; and

(c) either of the following has occurred:

1. A period of not less than three (3) months has passed from the date Physician billed the patient or responsible third party, during which time Physician has made reasonable efforts to obtain reimbursement and has not received payment for any portion of the amount billed.

2. Physician has received actual notification from the patient or responsible third party that no payment will be made for the services rendered.

Upon receipt of payment from the County under this claiming process, Physician must cease any current, and waive any future, collection efforts to obtain reimbursement from the patient or responsible third party. During the period after a claim has been submitted and prior to receipt of payment, the Physician can continue attempts to collect from a patient. However, once the Physician receives payment from the County, further collection efforts shall cease.

Examples of when these County collection efforts might occur would include, but not necessarily be limited to, situations where there are third-party tortfeasors responsible for a patient's medical expenses. If, after receiving payment from the County hereunder, Physician is reimbursed by a patient or a responsible third party, Physician shall immediately notify the County (see address below) in writing of the payment, and reimburse the County the amount received from the County.

MAKE REFUND CHECK PAYABLE TO:
County of Los Angeles/Department of Health Services

Refund checks should be accompanied by:
-- a copy of the Remittance Advice, and
-- a specific explanation for the refund, e.g., received payment for services from Medi-Cal, etc.

SUBMIT NOTIFICATION AND/OR REFUND TO:
County of Los Angeles/Department of Health Services
Special Funds Unit
313 North Figueroa Street, Room 531
Los Angeles, CA 90012
ATTN: CHIP Program

IV. CONDITIONS OF REIMBURSEMENT

Payment is contingent upon adherence to State law and County requirements regarding eligible claims, and provision of data as specified in these Billing Procedures.

V. CLAIM PERIOD

Claims may only be submitted for eligible services provided on/or after July 1, 2006 and through June 30, 2007. All claims for services provided during the fiscal year 2006/07 (July 1 through June 30) must be received by County's Claim Adjudicator no later than October 31, 2007. Claims received after this fiscal year deadline has passed will not be paid. Unless sooner terminated, canceled, or amended, this claim process shall expire on October 31, 2007.

VI. REIMBURSEMENT

Reimbursement of a valid claim hereunder will be limited to a maximum of 34% of the Official County Fee Schedule (OCFS), not to exceed 100% of Physician charges. The OCFS, which establishes rates of reimbursement deemed appropriate by the County, utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Based Relative Value Scale (RBRVS) unit values and a County determined weighted average conversion factor. The conversion factor for all medical procedures other than anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value.

Based on available funding, the initial payment rate for FY 2006/07 has been established at 29% of the OCFS. In order to ensure that all claims are paid at the same rate, this percentage figure may be increased to not more that 34%, based on the anticipated program revenue and the actual volume of claims.

VII. COMPLETION OF FORMS

A. Complete "Fiscal Year 2006/07 Conditions of Participation Agreement" for the current fiscal year Physician Services for Indigents Program (sample attached as Exhibit "D"). Submit one original signed Agreement to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340

B. Complete one HFCA-1500 Form per patient.

C. Complete one California Healthcare for Indigents Program ("CHIP") Form per patient (sample attached as Exhibit "D"). Physicians are required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. Additional requirements for data submission have been established. Refer to the Instructions for Submission of Claims and Data Collection (attached as Exhibit "C").

VIII. ELECTRONIC BILLING

As an option, the County's Claims Adjudicator can receive claims electronically. The record layout necessary for electronic submission shall be obtained directly from the County Claims Adjudicator at (800) 303-5242.

IX. SUBMIT CLAIM(S) TO COUNTY'S CONTRACTED CLAIMS ADJUDICATOR

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: PSIP

X. CLAIM REJECTION AND APPEALS

A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within 20 calendar days from the date of the rejection letter.

B. The Physician must submit an appeal of any denied claim within thirty (30) calendar days from the date of the denied Remittance Advice. A denied claim can be appealed once; however, after the appeal is dispositioned, a further appeal will not be considered. All appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

For Status of Claims, call:
AIA Physician Hotline - (800) 303-5242

For Program/Policy Issues, call:
Emergency Medical Services Agency
EMS Reimbursement Coordinator
(323) 890-7521

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies allocated therefor by the State and by the County of Los Angeles Board of Supervisors. To the extent such monies are available for expenditure under the Physician Services for Indigents Program, and until such available monies are exhausted, valid claims may be paid. Valid claims will be paid in the order of receipt; that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the PSIP. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the PSIP. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

In addition to any Physician duties specified previously herein, Physicians using this claiming process are obligated as follows:

A. Records/Audit Adjustment

1. Physician shall immediately prepare, and thereafter maintain, complete and accurate records sufficient to fully and accurately reflect the services provided, the costs thereof, all collection attempts from the patient and third-party payers, and revenue collected, if any, for which claim has been made under this claiming process.

2. All such records shall be retained by Physician at a location in Los Angeles County for a minimum of three (3) years following the last date of the Physician services to the patient.

3. Such records shall be made available during normal County working hours to representatives of the County and/or State, upon request, at all reasonable times during such three year period for the purposes of inspection, audit, and copying. Photocopying capability must be made available to County representatives during an on-site audit.

4. County may periodically conduct an audit of the Physician's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a single claim, a group of claims, or a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims.

Audited claims that do not comply with program requirements shall result in a refund to the County. If the audit was conducted on a statistically random sample

of claims, the dollar amount disallowed shall become a percentage of the total paid on the sample, referred to as the exception rate. The audit exception rate found in the sampled claims reflects, from a statistical standpoint, the overall exception rate potentially possible within the universe of adjudicated claims for that fiscal year. This exception rate shall be applied to the total universe of paid claims which will determine the final reimbursement due to the County.

If an audit of Physician or hospital records conducted by County and/or State representatives relating to the services for which claim was made and paid hereunder finds that (1) the records are incomplete or do not support the medical necessity for all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the claimed services, or (3) Physician failed either to report or remit payments received from patients or third parties as required herein, or (4) the patient was ineligible for services hereunder, or (5) Physician did not otherwise qualify for reimbursement hereunder, Physician shall, upon receipt of County billing therefor, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

County also reserves the right to exclude Physician from reimbursement of future claims for any failure to satisfy conditions of this claiming process.

B. Indemnification/Insurance

By utilizing this claiming process, the Physician certifies that the services rendered by him/her, and for which claim is made, are covered under a program of professional liability insurance with a combined single-limit of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate.

By utilizing this claiming process, the Physician further certifies that his/her workers' compensation coverage is in an amount and form to meet all applicable requirements of the California Labor Code, and that it specifically covers all persons providing services on behalf of the Physician and all risks to such persons.

C. Non-discrimination

In utilizing this claiming process, the Physician signifies that he/she has not discriminated in the provision of services for which claim is made because of race, color, religion, national origin, ancestry, sex, age, physical or mental disability, or medical condition and has complied in this respect with all applicable non-discrimination requirements of Federal and State law.

XIV. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ('HIPAA'). Contractor understands and agrees that, as a provider of medical treatment services, it is a 'covered entity' under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH ISINDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.

COUNTY OF LOS ANGELES ● DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

BILLING PROCEDURES

● ● ● Revised for Fiscal Year 2006/07 ● ● ●

I. INTRODUCTION

Pursuant to provisions of the State of California Welfare and Institutions Code, sections 16950 et seq., and Health and Safety Code ("HSC"), sections 1797.98a, et seq., a Physician Services Account has been established by the County of Los Angeles ("County") to pay for contracts with private physicians ("Physician") to provide reimbursement for certain professional services they have rendered to eligible indigent patients. County has determined that a portion of the Physician Services Account should be allocated to a special County sub-account which will serve as a source of reimbursement for otherwise uncompensated physician services rendered to trauma patients in hospitals designated by County contract as trauma hospitals.

This document defines the procedures which must be followed by a Physician in seeking reimbursement from this trauma services sub-account. Reimbursement is also limited to the policy parameters set forth in the "Department of Health Services' Physician Reimbursement Policies, Revised for Fiscal Year 2006/07", attached as Exhibit "A" and incorporated herein by reference. The County may revise such policies from time to time as deemed necessary or appropriate and if approved by the Board of Supervisors.

Submission of a claim for trauma services by a Physician under these procedures establishes (1) a contractual relationship between the County and the Physician covering the services provided and (2) signifies the Physician's acceptance of all terms and conditions herein.

This claiming process is only valid for trauma services rendered during the period July 1, 2006 through June 30, 2007.

In no event may this claiming process be used by a Physician if his/her services are included as part of the trauma hospital services claimed for reimbursement by the hospital under County's contract with the hospital.

This claiming process may not be used by a Physician for services for which a billing has previously been submitted or could be submitted to the County under any other County contract or claiming process.

This claiming process may not be used by a physician if he or she is an employee of a County trauma hospital.

II. PHYSICIAN ELIGIBILITY

A. The Physician must complete a current fiscal year Trauma Physician Services Program "Conditions of Participation Agreement" and "Program Enrollment Provider Form" and provide them to the County's Office of Emergency Medical Services ("EMS") Agency in care of the contracted Claims Adjudicator (see address on page 4). Physician claims will not be accepted if said Agreement and form are not on file with the EMS Agency. A copy of the "Conditions of Participation Agreement" and "Program Enrollment Provider Form" are attached hereto as Exhibit "B" and incorporated herein by reference.

B. Any Physician, **including an emergency department Physician,** who responds as part of an organized system of trauma care to eligible patients in a hospital designated by formal County contract as a "trauma hospital" may submit a claim hereunder. (Physician employees of a County trauma hospital are not, however, eligible for reimbursement under this claiming process.)

C. Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.

III. PATIENT ELIGIBILITY/BILLING EFFORTS

Patients covered by this claiming process are only those for whom the trauma hospital is required to complete a trauma patient summary ("TPS") form, and who do not have health insurance coverage for emergency services and care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, including Medi-Cal, but with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

During the time prior to submission of the bill to the County, the Physician must have made reasonable efforts to obtain reimbursement and not received payment for any portion of the amount billed. For purposes of this claim process, reimbursement for unpaid Physician billings shall be limited to the following:

(a) patients for whom a Physician has conducted reasonable inquiry to determine if there is a responsible private or public third-party source of payment; and

(b) patients for whom a Physician has billed all possible payment sources, but has not received reimbursement for any portion of the amount billed; and

(c) either of the following has occurred:

1. A period of not less than three (3) months has passed from the date the Physician billed the patient or responsible third party, during which time the Physician has made reasonable efforts to obtain reimbursement and has not received payment for any portion of the amount billed.

2. The Physician has received actual notification from the patient or responsible third party that no payment will be made for the services rendered.

Upon receipt of payment from the County under this claiming process, Physician must cease any current, and waive any future, collection efforts to obtain reimbursement from the patient or responsible third party. During the period after a claim has been submitted and prior to receipt of payment, the Physician can continue attempts to collect from a patient. However, once the Physician receives payment from the County, further collection efforts shall cease.

Examples of when these County collection efforts might occur would include, but not necessarily be limited to, situations where there are third-party tortfeasors responsible for a patient's medical expenses. If, after receiving payment from the County hereunder, Physician is reimbursed by a patient or a responsible third party, Physician shall immediately notify the County (see address below) in writing of the payment, and reimburse the County the amount received from the County.

MAKE REFUND CHECK PAYABLE TO:
County of Los Angeles/Department of Health Services

Refund checks should be accompanied by:
-- a copy of the Remittance Advice, and
-- a specific explanation for the refund, e.g., received payment for services from Medi-Cal, etc.

SUBMIT NOTIFICATION AND/OR REFUND TO:
County of Los Angeles/Department of Health Services
Special Funds Unit
313 North Figueroa Street, Room 531
Los Angeles, CA 90012
ATTN: **CHIP** Program

IV. CONDITIONS OF REIMBURSEMENT

Payment is contingent upon adherence to State law and County requirements regarding eligible claims, and provision of data as specified in these Billing Procedures.

V. CLAIM PERIOD

Claims may only be submitted for eligible services provided on/or after July 1, 2006 and through June 30, 2007. All claims for services provided during the fiscal year 2006/07 (July 1 through June 30) must be received by County's Claim Adjudicator no

later than October 31, 2007. Claims received after this fiscal year deadline has passed will not be paid. Unless sooner terminated, canceled, or amended, this claim process shall expire on October 31, 2007.

VI. REIMBURSEMENT

Reimbursement of a valid claim hereunder will be limited to a maximum of 50% of the Official County Fee Schedule (OCFS), not to exceed 100% of Physician charges. The OCFS, which establishes rates of reimbursement deemed appropriate by the County, utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Based Relative Value Scale (RBRVS) unit values and a County determined weighted average conversion factor. The conversion factor for all medical procedures other than anesthesiology is $79.49 per relative unit value. The conversion factor for anesthesiology procedures is $48.77 per relative unit value.

VII. COMPLETION OF FORMS

A. Complete "Fiscal Year 2006/07 Conditions of Participation Agreement" for the current fiscal year Trauma Physician Services Program (sample attached). Submit one original signed Agreement to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340

B. Complete one HFCA-1500 Form per patient.

C. Complete one California Healthcare for Indigents Program ("CHIP") Form per patient (sample attached as Exhibit "D"). Physicians are required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. Additional requirements for data submission have been established. Refer to the Instructions for Submission of Claims and Data Collection (attached as Exhibit "C").

VIII. ELECTRONIC BILLING

As an option, the County's Claims Adjudicator can receive claims electronically. The record layout necessary for electronic submission shall be obtained directly from the County Claims Adjudicator at (800) 303-5242.

IX. SUBMIT CLAIM(S) TO COUNTY'S CONTRACTED CLAIMS ADJUDICATOR

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340

ATTN: TRAUMA CLAIMS

X. CLAIM REJECTION AND APPEALS

A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within 20 calendar days from the date of the rejection letter.

B. The Physician must submit an appeal of any denied claim within thirty (30) calendar days from the date of the denied Remittance Advice. A denied claim can be appealed once; however, after the appeal is dispositioned, a further appeal will not be considered. All appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

For Status of Claims, call:
AIA Physician Hotline - (800) 303-5242

For Program/Policy Issues, call:
Emergency Medical Services Agency
EMS Reimbursement Coordinator
(323) 890-7521

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies allocated therefor by the State and by the County of Los Angeles Board of Supervisors. To the extent such monies are available for expenditure, valid claims may be paid. Valid claims will be paid in the order of receipt; that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the PSIP. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the Trauma Services for Indigents Program. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

In addition to any Physician duties specified previously herein, Physicians using this claiming process are obligated as follows:

A. Records/Audit Adjustment

1. Physician shall immediately prepare, and thereafter maintain, complete and accurate records sufficient to fully and accurately reflect the services provided, the costs thereof, all collection attempts from the patient and third-party payers, and revenue collected, if any, for which claim has been made under this claiming process.

2. All such records shall be retained by Physician at a location in Los Angeles County for a minimum of three (3) years following the last date of the Physician services to the patient.

3. Such records shall be made available during normal County working hours to representatives of the County and/or State, upon request, at all reasonable times during such three year period for the purposes of inspection, audit, and copying. Photocopying capability must be made available to County representatives during an on-site audit.

4. County may periodically conduct an audit of the Physician's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a single claim, a group of claims, or a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims.

Audited claims that do not comply with program requirements shall result in a refund to the County. If the audit was conducted on a statistically random sample of claims, the dollar amount disallowed shall become a percentage of the total paid on the sample, referred to as the exception rate. The audit exception rate found in the sampled claims reflects, from a statistical standpoint, the overall exception rate potentially possible within the universe of adjudicated claims for that fiscal year. This exception rate shall be applied to the total universe of paid claims which will determine the final reimbursement due to the County.
If an audit of Physician or hospital records conducted by County and/or State representatives relating to the services for which claim was made and paid hereunder finds that (1) the records are incomplete or do not support the medical necessity for all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the claimed services, or (3) Physician failed either to report or remit payments received from patients or third parties as

required herein, or (4) the patient was ineligible for services hereunder, or (5) Physician did not otherwise qualify for reimbursement hereunder, Physician shall, upon receipt of County billing therefor, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

County also reserves the right to exclude Physician from reimbursement of future claims for any failure to satisfy conditions of this claiming process.

B. Indemnification/Insurance

By utilizing this claiming process, the Physician certifies that the services rendered by him/her, and for which claim is made, are covered under a program of professional liability insurance with a combined single-limit of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate.

By utilizing this claiming process, the Physician further certifies that his/her workers' compensation coverage is in an amount and form to meet all applicable requirements of the California Labor Code, and that it specifically covers all persons providing services on behalf of the Physician and all risks to such persons.

C. Non-discrimination

In utilizing this claiming process, the Physician signifies that he/she has not discriminated in the provision of services for which claim is made because of race, color, religion, national origin, ancestry, sex, age, physical or mental disability, or medical condition and has complied in this respect with all applicable non-discrimination requirements of Federal and State law.

XIV. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ('HIPAA'). Contractor understands and agrees that, as a provider of medical treatment services, it is a 'covered entity' under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH ISINDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.

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COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR SUBMISSION OF CLAIMS AND DATA COLLECTION

• • • Revised for Fiscal Year 2006/07 • • •

GENERAL INFORMATION

Physicians must submit both a **HCFA-1500 Form** and a **CHIP Form** for each patient's care if they are claiming reimbursement under the County's private physician California Healthcare for Indigents Program (CHIP). Information from both the CHIP Form and the HCFA-1500 Form are used by the County to comply with State reporting mandates. **An original CHIP form must be completed for each patient. Xeroxed documents/information will be rejected.**

PATIENT INFORMATION: Physicians are required to make reasonable efforts to collect all data elements; however, physicians are only required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. If, after reasonable efforts are made, some data elements cannot be obtained, indicate "N/A" (not available) in the space for the data element which was not obtainable. **Claims for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT shall not be accepted without completion of all data elements unless a reasonable justification is provided.**

MEDI-CAL ELIGIBILITY: Procedures continue to be in place to run all FY 2006/07 claims against the State's Medi-Cal Eligibility Tape. Claims which match both patient and month of service will not be paid by the CHIP program. The physician will be provided with the patient's Medi-Cal number so that the physician can bill Medi-Cal.

ALL CLAIMS should be submitted to American Insurance Administrators.

TRAUMA PHYSICIANS - SUBMIT CLAIMS:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
Attention: **TRAUMA CLAIMS**

ALL OTHER PHYSICIANS--SUBMIT CLAIMS TO:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
Attention: **PSIP CLAIMS**

Contact: AIA Physician Hotline - (800) 303-5242

COMPLETION OF CHIP FORM

PATIENT INFORMATION (Items #1-10)

1. TPS #

Enter Trauma Patient Summary number if claim is for a contract trauma patient. If claim is for a non-trauma patient, leave box blank.

2. SOCIAL SECURITY #

Enter Patient's social security number. Failure to provide the social security number must be justified in item # 26 (REASON) of the CHIP Form.

3. PATIENT'S NAME

Enter Patient's last name, first name, and middle initial. (1) If Patient is a minor, parent/guardian name must be provided.

4. PLACE OF BIRTH

Enter Patient's city, state, and country of birth.

5. MOTHER'S MAIDEN NAME

Enter Patient's mother's maiden name.

6. ETHNICITY

Check appropriate box to indicate Patient's racial/ethnic background:

(1) white
(2) black
(3) asian/pacific islander
(4) native american/eskimo/aleut
(5) hispanic
(6) filipino
(7) other (or none of the above)

7. EMPLOYMENT TYPE

Check appropriate box to indicate occupation of Patient or Patient's family's primary wage earner:

(0) unemployed
(1) farming/forestry/fishing
(2) laborers/helpers/craft/inspection/repair/production/transportation
(3) sales/service
(4) executive/administrative/managerial/professional/technical/related support
(5) other

*** **Note: Employment type must be consistent with required employment information**

provided on the HCFA-1500. Claims with inconsistent information will be rejected.

8. MONTHLY INCOME

Enter total of Patient's or Patient's family's primary wage earner's wages and salaries (including commissions, tips, and cash bonuses), net income from business or farm, pensions, dividends, interest, rents, welfare, unemployment or workers' compensation, alimony, child support, and any money received from friends or relatives during the previous month by all related family members currently residing in the patient's household.

9. FAMILY SIZE

Enter the number of individuals related by birth, marriage, or adoption who usually share the same place of residence (including any active duty members of the military who are temporarily away from home). This number includes a head of household who is responsible for payment, and all of this person's dependents. The following family members should be included in the family size:

- parent(s)
- children under 21 years of age living in the home. A child under 21 years of age who is in the military would be counted only if he/she gave his/her entire salary to the parent(s) for support of the family.
- children under 21 years of age living out of the home but supported by the parent(s), e.g., a child in college

*** **Note: For a minor child, entering one (1) in family size will result in rejection.**

10. SOURCE OF INCOME

Check appropriate box to indicate the primary source (largest single source) of family income:

(0) none
(1) general relief
(2) wages
(3) self-employed
(4) disability
(5) retirement
(6) other, e.g., unemployment/VA benefits/interest/dividends/rent/child support/alimony, etc.

PATIENT INFORMATION VERIFICATION (Items #26-27)

26. REASON(S)

If Patient Information is not available for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT, submitting physician/agency is required to enter a reason(s) why information was not obtained and N/A was indicated. All reasonable efforts must be taken to obtain patient information from the hospital.

*** **Note: N/A will only be accepted for patients seen through the emergency department. Patients admitted to the hospital (INPATIENT) and seen as a doctor's appointment**

(OUTPATIENT/OFFICE VISIT) shall not be accepted without completion of all data elements unless a reasonable justification is provided.

27. SIGNATURE

If Patient Information is not available for services provided to patients as INPATIENT or OUTPATIENT/OFFICE VISIT, enter a signature of the physician/submitting agency attesting to the fact that every attempt to obtain information was made. If all data elements are complete, a signature is not required.

PHYSICIAN SERVICES (Items #20-25)

20. PHYSICIAN FUND

Check appropriate box to indicate type of claim being submitted:

(1) **CONTRACT TRAUMA** -trauma care provided at the following hospitals:

California Hospital Medical Center
Cedars-Sinai Medical Center
Childrens Hospital Los Angeles
Henry Mayo Newhall Memorial Hospital
Holy Cross Medical Center
Huntington Memorial Hospital
Memorial Hospital Medical Center of Long Beach
Northridge Hospital Medical Center
St. Francis Medical Center
St. Mary Medical Center
UCLA Medical Center
Other hospitals as approved by the Board of Supervisors and designated by the EMS Agency

(2) **NON-CONTRACT EMERGENCY** - all emergency services provided by a licensed Physician excluding specialty care provided by a designated contract trauma hospital as per (1) above.

(3) **PEDIATRICS** - pediatric services means all medical services rendered by any licensed Physician to persons from birth to 21 years of age, and shall include attendance at labor and delivery.

(4) **OBSTETRICS** - obstetric services means the diagnosis of pregnancy and all other medical services provided by a licensed Physician to a pregnant woman during her pregnancy from the time of conception until 90 days following the end of the month in which the pregnancy ends.

*** Note: **If "Obstetrics" is checked, the Expected Date of Delivery (EDD) must be entered.**

21. SERVICE SETTING
Check one of the following:

(1) inpatient
(2) emergency department
(3) outpatient/office visit, CHECK ONE OF: (a) primary care (b) specialty care

***** Note: If (1) INPATIENT or (2) OUTPATIENT/OFFICE VISIT is checked, items #2-10 cannot indicate "N/A" (not available) unless a reasonable justification is indicated in item #26 (REASON).**

22. PHYSICIAN'S NAME AND STATE LICENSE NUMBER

Enter Physician's name and State license number.

23. PAYEE NAME, ADDRESS AND TAX ID NUMBER

Enter payee name, address, and nine (9) digit federal tax ID number.

24. DATE BILLED COUNTY

Enter date Physician billed the County.

CHARGES

Enter total amount of Physician charges.

25. CONTACT PERSON/TELEPHONE NO.

Enter name and telephone number of individual authorized to answer questions regarding the claim.

COMPLETION OF HCFA-1500 FORM

The following HCFA-1500 items must be completed:

Patient's Name (last, first, middle initial)

Patient's Date of Birth and Sex

Patient's Address (city, state, zip)

Employment Information

*** **Note:** **All employment information must be consistent with CHIP Form, item #7(EMPLOYMENT TYPE).**

Hospitalization Dates Related to Current Services (Admission and Discharge dates)

*** **Note:** **Hospital admit and discharge dates that are equal (i.e., 07-01-06 to 07-01-06) in box 18 must have an explanation in box 19 (Reserved for Local Use)**

Diagnoses (primary and two others)

Date of Service

Procedures (descriptions)

Patient's Account No.

Name and Address of Facility Where Services Were Rendered

The HCFA-1500 section at the top of the form indicating *Medicare, Medicaid, Champus, Group Health Plan, Other,* will only be accepted when *Other* is checked or the section is left blank. If any other box is checked (*Medicare, Medicaid, Group Health Plan, etc.*), the claim will be rejected.

When completing Section Number 24 (A thru K) all lines are to be utilized before going on to another HCFA-1500 form.

ATTACHMENT A-10

PSIP CLAIMS PROCESSING SERVICES

SAMPLE REMITTANCE ADVICE (RA) SPECIFICATIONS

1. CONTRACTOR's Name
2. Fiscal year of service
3. Bill Type (i.e., "trauma", "emergency", "pediatrics". etc.)
4. Warrant Number
5. Warrant Issue Date
6. Heading: County of Los Angeles
   Department of Health Services
   Physician Reimbursement Program
   Remittance Advice – Fiscal Year 2006-07
7. Payee Tax Identification Number
8. Payee's Name and Address
9. Report Date
10. Patient's Social Security Number (Patient ID) / Bill Number
11. Patient's Name (Last name, First name)
12. Patient Account Number
13. Hospital Code
14. Physician License Number
15. Date of service
16. Procedure Code – List all codes involved
17. Amount billed on the claim
18. Adjudicated amount
19. Percentage of adjudicated amount to be paid
20. Amount to be paid
21. Remark Code, if applicable
22. Received date
23. Medi-Cal and Medicare No.
24. Rate %
25. Totals for Paid Claims, by patient:
    a. Amount Billed.
    b. Charges not covered
    c. Adjudicated Amount, and
    d. Amount Paid
26. Totals for Denied Claims, by patient (if applicable):
    a. Amount Billed.
    b. Amount Medi-Cal Denied.
    c. Amount Plan Denied
27. Any other pertinent information

ATTACHMENT A-11

PSIP CLAIMS PROCESSING SERVICES

CONTRACT PHYSICIAN PROFILE RECORD LAYOUT

The following is the list of required data elements for the contract physician's profile to be sent to the MICRS staff at the Department of Health Services, Health Services Administration. Data file shall be transmitted via email or made available on-line for downloading, monthly.

#	FIELD NAME	FLD TYPE	FLD LEN	DESCRIPTION (FROM PHYSICIAN APPLICATION FORM)
RECORD B				
1	PRVDR- NAME	A	50	Physician's Name
2	PRVDR STR	A	25	Physician's Office Address
3	PRVDR CITY	A	20	Physician's Office City
4	PRVDR STATE	A	2	Physician's Office State
5	PRVDR ZIP	A	9	Physician's Office Zip Code
6	PRVDR PHON	A	13	Physician's Office Telephone
7	PRVDR CONT	A	50	Physician's Contact Person
8	PRVDR EMAIL	A	20	Physician's Contact Person Email
9	PRVDR SPEC	A	25	Physician's Primary Specialty
10	PRVDR-ID		9	Physician's State License Number
11	PRVDR UPIN	A	15	Physician's U.P.I.N.
12	PRVDR-TID	A	15	Physician's Payee Tax I. D. Number
13	SITE NAME	A	30	Billing Company Name
14	SITE STR	A	25	Billing Company Address
15	SITE CITY	A	20	Billing Company City
16	SITE STATE	A	2	Billing Company State
17	SITE ZIP	A	9	Billing Company zip Code
RECORD A				
1	PAYEE- NAME	A	50	Payee's Name
2	PAYEE STR	A	25	Payee's Office Address
3	PAYEE CITY	A	20	Payee's Office City
4	PAYEE STATE	A	2	Payee's Office State
5	PAYEE ZIP	A	9	Payee's Office Zip Code
6	PAYEE PHON	A	13	Payee's Office Telephone
7	PAYEE CONT	A	50	Payee's Contact Person
8	PAYEE EMAIL	A	20	Payee's Contact Person Email

ATTACHMENT A-12

PHYSICIAN SERVICES FOR THE INDIGENT PROGRAM (PSIP)

MEDICALLY INDIGENT CARE REPORTING SYSTEM (MICRS)

STATEMENT OF WORK

I. GENERAL SCOPE OF WORK

CONTRACTOR shall fully perform, complete and deliver on time all work, deliverables and/or other items, however denoted, as set forth below and in documents attached and referenced herein, in full compliance with the requirements of this Statement of Work.

The general responsibilities of CONTRACTOR under this Agreement shall include, but not be limited to, all labor required to establish data base(s) in order to meet State Department of Health Services ('STATE") and County of Los Angeles ("COUNTY") Physician Services for Indigents Program reporting requirements, produce STATE required data and submit to COUNTY, as described herein and in Attachment A-13 (MICRS Record Lay-Out/MICRS Dictionary) and Attachment A-14 (MICRS Code Tables).

CONTRACTOR will also provide test data for MICRS to ensure that the record layout and format are consistent with program requirements. The test data are due thirty (30) days after adjudication of the first **400** physician claims.

II. BACKGROUND AND OVERVIEW

AB 75 and subsequent legislation implementing the Tobacco Tax and Health Protection Act of 1998 require all counties to report health care costs, utilization and patient demographic data to the STATE. As a result, STATE has mandated COUNTY report the required data by establishing the Medically Indigent Care Reporting System (MICRS) beginning with Fiscal Year 1991-92 and on-going.

This Statement of Work describes the services required of CONTRACTOR to provide data elements from Physician reimbursement claims to the COUNTY in order to meet STATE reporting requirements. The following are procedures for the timely submission of data to COUNTY.

III. PROJECT MANAGEMENT

The County of Los Angeles Department of Health Services' (DHS) Project Manager shall administer the contract and ensure that CONTRACTOR meets or exceeds the contract requirements. The project coordination between CONTRACTOR and COUNTY shall be through the COUNTY's MICRS Project Manager, unless otherwise designated by Director.

IV. DATA REQUIREMENTS AND SUBMISSION PROCEDURES

A. DATA REQUIREMENTS

CONTRACTOR shall prepare MICRS data in the required format, and informational/data requests on an ad-hoc basis. CONTRACTOR shall provide a CD copy, or via a secure electronic data transfer (i.e. ftp – file transfer protocol), of the Contract Physicians Profile file (i.e., Physician Profile Data base (PPD) as described herein and in Attachment A-11 (Contract Physicians Profile Record Layout).

- MICRS Data Requirements

CONTRACTOR will be responsible to collect and maintain current information on Physicians as well as provide the patient utilization information as described in Attachments A-13 (MICRS Record Layout/MICRS Dictionary) and A-14 (MICRS Code Tables).

The MICRS data will be utilized by COUNTY as required by STATE and submitted as annual reports to STATE

CONTRACTOR shall inform COUNTY of any update to the Contract Physicians Profile file (i.e. Physician Profile Data base (PPD) by submitting a copy of the completed Physician Enrollment Form included as Attachment A-5.

B. DATA SUBMISSION PROCEDURES

- MICRS Data Submission Procedures

CONTRACTOR shall prepare and submit, via email, MICRS data to DHS, Health Services Administration, Attention: MICRS Unit.

CONTRACTOR shall format the data according to the record lay-out included in Attachments 13 and 14 (MICRS Record Lay-out/MICRS Dictionary and MICRS Code Tables) and submit the data in a fixed block, ASCII format. CONTRACTOR shall recognize that COUNTY data format requirements may change from time to time as a result of STATE program requirements or COUNTY information requirements, and CONTRACTOR must be able to adjust accordingly.

The data will be submitted on computer media CD, or via a secure electronic data transfer (i.e. ftp – file transfer protocol), which includes the labeling format and mailing address for submitting MICRS data as well as Contract Physician Profile information (i.e. Physician Profile Data base (PPD).

CONTRACTOR is responsible to ensure that the data are correctly identified, appropriately labeled, and loaded on CD or transmitted via a secure electronic data transfer (i.e. ftp – file transfer protocol).

COUNTY shall inspect and review MICRS data provided by CONTRACTOR and reject all improperly formatted or unreadable data within ten (10) work days after receipt thereof CONTRACTOR shall correct such data without additional cost to COUNTY.

ATTACHMENT 13

MICRS RECORD LAYOUT/MICRS DICTIONARY

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION
Oracle - PSIP Data Mapping

Record Set: PSIP

DATABASE TABLE and COLUMN	DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY
CLAIM/ PAT_LNAME	(1) PATIENT LAST NAME	1	20	20	LEFT/ALPHANUMERIC
CLAIM/ PAT_FNAME	(2) PATIENT FIRST NAME	21	35	15	LEFT/ALPHANUMERIC
CLAIM/ PAT_MNAME	(3) PATIENT MIDDLE NAME	36	50	15	LEFT/ALPHANUMERIC
CLAIM/ DOB	(4) DATE OF BIRTH	51	58	8	DATE
CLAIM/ SEX	(5) SEX	59	59	1	LEFT/ALPHANUMERIC
CLAIM/ ETHN_RACE	(6) ETHNICITY	60	60	1	LEFT/ALPHANUMERIC
CLAIM/ MRUN	(7) PF #	61	69	9	LEFT/ALPHANUMERIC
CLAIM/ MOTHER_MAIDEN_NAME	(8) MOTHER MAIDEN NAME	70	89	20	LEFT/ALPHANUMERIC
CLAIM/ SSN	(9) SOCIAL SECURITY NO.	90	98	9	LEFT/ALPHANUMERIC
CLAIM/ MCAL_NBR	(10) MEDI-CAL IDENTIFICATION #	99	113	15	LEFT/ALPHANUMERIC
CLAIM/ PAT_ADDR	(11) RESIDENCE ADDRESS	114	148	35	LEFT/ALPHANUMERIC
CLAIM/ PAT_CITY	(12) RESIDENCE CITY NAME	149	168	20	LEFT/ALPHANUMERIC
CLAIM/ PAT_STATE	(13) RESIDENCE STATE NAME	169	170	2	LEFT/ALPHANUMERIC
CLAIM/ PAT_ZIP	(14) RESIDENCE ZIP CODE	171	175	5	LEFT/ALPHANUMERIC
CLAIM/ PAT_BIRTH_CITY	(15) PATIENT BIRTH CITY NAME	176	195	20	LEFT/ALPHANUMERIC
CLAIM/ PAT_BIRTH_STATE	(16) PATIENT BIRTH STATE NAME	196	215	20	LEFT/ALPHANUMERIC
CLAIM/ PAT_BIRTH_COUNTRY	(17) PATIENT BIRTH COUNTRY NAME	216	235	20	LEFT/ALPHANUMERIC
CLAIM/ FAM_SIZE	(18) FAMILY SIZE	236	237	2	RIGHT/ZERO PADDED
CLAIM/ MON_INC	(19) MONTHLY INCOME	238	243	6	RIGHT/ZERO PADDED
CLAIM/ INC_CRC	(20) SOURCE OF INCOME	244	244	1	LEFT/ALPHANUMERIC
CLAIM/ EMP_TYPE	(21) TYPE OF EMPLOYMENT	245	245	1	LEFT/ALPHANUMERIC
CLAIM/ PRIN_DX_CODE	(22) PRINCIPAL DISCHARGE DIAGNOSIS	246	250	5	LEFT/ALPHANUMERIC
CLAIM/ SCNDRY_DX_CODE	(23) OTHER DIAGNOSIS A	251	255	5	LEFT/ALPHANUMERIC
CLAIM/ TRTRY_DX_CODE	(24) OTHER DIAGNOSIS B	256	260	5	LEFT/ALPHANUMERIC
CLAIM/ PROC_CODE_PRIN	(25) PRINCIPAL PROCEDURE CODE	261	265	5	LEFT/ALPHANUMERIC
CLAIM/ PROC_CODE_SCNDRY	(26) OTHER PROCEDURES & SERVICES A	266	270	5	LEFT/ALPHANUMERIC

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION
Oracle - PSIP Data Mapping

Record Set: PSIP

DATABASE TABLE and COLUMN	DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY
CLAIM/ PROC_CODE_TRTRY	(27) OTHER PROCEDURE & SERVICES B	271	275	5	LEFT/ALPHANUMERIC
CLAIM/ SVC_SET_CODE	(28) SERVICE SETTING CODE	276	277	2	RIGHT/ZERO PADDED
CLAIM/ SVC_UNIT_CODE	(29) SERVICE UNIT CODE	278	279	2	RIGHT/ZERO PADDED
CLAIM/ SVC_UNIT_QTY	(30) SERVICE UNIT QUANTITY	280	283	4	RIGHT/ZERO PADDED
CLAIM/ ER_PRTY_FLAG	(31) EMERGENCY ROOM PRIORITY FLAG	284	284	1	LEFT/ALPHANUMERIC
CLAIM/ ER_DISP_CODE	(32) EMERGENCY ROOM DISPOSITION	285	285	1	LEFT/ALPHANUMERIC
CLAIM/ SVC_EVENT_CODE	(33) SERVICE EVENT	286	287	2	RIGHT/ZERO PADDED
CLAIM/ SVC_EVENT_DATE	(34) SERVICE EVENT DATE	288	295	8	DATE
CLAIM/ ENC_DATE	(35) ENCOUNTER DATE	296	303	8	DATE
CLAIM/ OP_SVC_TYPE	(36) TYPE OF OUTPATIENT SERVICES	304	305	2	RIGHT/ZERO PADDED
CLAIM/ CLINIC_CODE	(37) CLINIC CODE	306	310	5	LEFT/ALPHANUMERIC
CLAIM/ SVC_EVENT_CHRG_AMT	(38) SERVICE EVENT CHARGE AMOUNT	311	319	9	RIGHT/ZERO PADDED
CLAIM/ AMT_PAID	(39) AMOUNT PAID (EXPENDITURES)	320	328	9	RIGHT/ZERO PADDED
CLAIM/ CAR_CODE_PRIM	(40) CARRIER CODE/PRIMARY	329	331	3	LEFT/ALPHANUMERIC
CLAIM/ CAR_CODE_SCNDRY	(41) CARRIER CODE/SECONDARY	332	334	3	LEFT/ALPHANUMERIC
CLAIM/ CAR_CODE_TRTRY	(42) CARRIER CODE/TERTIARY	335	337	3	LEFT/ALPHANUMERIC
CLAIM/ PAYER_PAID_AMT_PRIM	(43) PAYER PAID AMOUNT/PRIMARY	338	346	9	RIGHT/ZERO PADDED
CLAIM/ PAYER_PAID_AMT_SCNDRY	(44) PAYER PAID AMOUNT/SECONDARY	347	355	9	RIGHT/ZERO PADDED
CLAIM/ PAYER_PAID_AMT_TRTRY	(45) PAYER PAID AMOUNT/TERTIARY	356	364	9	RIGHT/ZERO PADDED
CLAIM/ PROV_ID	(46) PROVIDER IDENTIFIER #	365	373	9	LEFT/ALPHANUMERIC
CLAIM/ PROV_SITE_ID	(47) PROVIDER SITE ID	374	382	9	LEFT/ALPHANUMERIC
CLAIM/ REF_SRC	(48) REFERRAL SOURCE	383	388	6	LEFT/ALPHANUMERIC
CLAIM/ REC_SRC	(49) RECORD SOURCE	389	390	2	RIGHT/ZERO PADDED
CLAIM/ TPS_NO	(50) TPS #	391	398	8	LEFT/ALPHANUMERIC
CLAIM/ MED_SVCS	(51) MEDICAL SERVICES	399	403	5	LEFT/ALPHANUMERIC
CLAIM/ NURS_STAT	(52) NURSING STATIONS	404	408	5	LEFT/ALPHANUMERIC

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION
Oracle - PSIP Data Mapping

Record Set: PSIP

DATABASE TABLE and COLUMN	DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY
CLAIM/ SSN2	(53) SOCIAL SECURITY NO. - 2	409	417	9	LEFT/ALPHANUMERIC
CLAIM/ BILL_NBR	(54) BILL NUMBER	418	420	3	RIGHT/ZERO PADDED
CLAIM/ PF_TYPE	(55) PF TYPE	421	421	1	LEFT/ALPHANUMERIC
CLAIM/ AMT_PAID2	(56) AMOUNT PAID - 2	422	429	8	RIGHT/ZERO PADDED
CLAIM/ RFND_CNCL	(57) REFUND/CANCEL CODE	430	430	1	LEFT/ALPHANUMERIC
CLAIM/ ISSUE_DATE	(58) ISSUED DATE	431	436	6	DATE
CLAIM/ CANCEL_DATE	(59) CANCEL DATE	437	442	6	DATE

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Amount Paid (Expenditures)	The total dollars expended for defined units of service rendered to county patients. (OP visits, IP days, ancillaries)
Carrier Code	A billing code assigned by different facilities. (Three occurrences: Primary carrier code, and two others: Secondary carrier code & tertiary carrier code)
Carrier Paid Amount	The amount paid by a payer for medical services. (Three occurrences: Primary payer paid amount, and two others: Secondary payer paid amount & tertiary payer paid amount)
Census Tract	A statistical subdivision of a Standard of Metropolitan Area with an average population of 4,000.
Clinic Code	The code which specifies hospital outpatient clinic or comprehensive health clinic or community (free-standing) clinic providing services (applicable to sub-projects).
Date of Birth	The month, day, century and year of a person's birth. Used to calculate age at the time of an event. [MMDDCCYY]
Emergency Room Disposition	The code indicating the disposition of patient from an emergency room setting.
Emergency Room Flag	A flag indicating that an immediate action or remedy is required. This distinguishes emergency and non-emergency.
Encounter Date	The month, day, century and year of an outpatient encounter.

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Ethnicity	The code used to designate race or ethnicity.
Family Size	Based on AFP family size definition (Please see attached memo).
HIV DATE	The month, day, century, and year of HIV positive diagnosis.
HIV FLAG	A flag indicating the HIV status of the patient. (0= Non-HIV positive or undetermined, 1= HIV positive)
MICRS Flag	In Patient file a flag that is set if at least one visit is considered indigent in reporting period. In Patient Utilization file a flag indicates the patient is indigent for that visit.
Medi-Cal Identification #	The Medi-Cal identifier issued by the State of California to the patient receiving medical services.
Monthly Income	The total monthly income received for the previous month by all related family members residing with patients. (For more detailed information, please check RFA on page A-6)
Mother Maiden Name	The surname or family name of the mother of the patient.
Other Diagnosis	A diagnosis which may have developed subsequently and have affected the treatment rendered or the length of stay. (Two occurrences: Other diagnosis A, other diagnosis B)
Other Procedures and Services	Other procedures may include any extraordinary interventions, particularly invasive diagnostics during a period of hospitalization. (Two occurrences: Other procedure A, other procedure B

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
PT#	Permanent file # assigned by each facility to a patient record.
Patient Birth City Name	The name of the city, town or village where the patient was born.
Patient Birth Country Name	The name of the country where the patient was born.
Patient Birth State Name	The name of the political subdivision of the country where the patient was born (state, province, district, etc.).
Patient First Name	The full first or given name of the patient, minimally the first name initial.
Patient Last Name	The full surname or family name of the patient.
Patient Middle Name	The full middle name of the patient when it is available. Minimally, the middle name initial.
Patient Unique ID	The patient identifier is a unique identifier that distinguishes a patient and the records concerning that patient's medical care from all other patients, across all facilities.
Payer Contact Name	The name of contact person of payer of medical service charges.
Payer ID	A unique identifier for a payer.
Payer Name	The name of a payer of medical service charges.
Payer Phone#	The phone number of a payer of medical service charges.

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Payer Summary ID	A unique identifier for aggregating totals for a payer of medical service charges having a multiple payer identifier.
Payer mail address	The mail address of a payer of medical service charges.
Principle Discharge Diagnosis	The condition which has been established to have been the chief cause of admission for care.
Principle Procedure Code	The procedure which was performed for definitive treatment rather than diagnostic or exploratory purposes, unless these were the only types of procedures rendered during the event.
Provider Contact Name	The name of the contact person of a provider of medical service.
Provider Identifier #	A unique identifier for a provider (hospital OSHPD number).
Provider Mail Address	The mail address for a provider of medical service.
Provider Name	The name of a provider of a medical service.
Provider Phone #	The phone # for a provider of medical service.
Provider Site Address	The site address for a provider of medical service.
Provider Site Id	Provider site identification number for CPO.
Provider Summary ID	A unique identifier for a provider of medical service having multiple provider identifiers.

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Provider Zip Code#	The provider's zip code used for indicating location.
Provider-Relation to LACO	The code used to designate the category of organizational or contract relationship to the County indigent care program.
ROV Place Code	A two digit code used by Registrar Recorder to designate a city or unincorporated area of the County.
Record Source	The code used to designate the source code for each feeder system (Sub-Project).
Referral Source	Source of referral for incident of care. Examples: CHDP, HHRCHC, private physician. Field should be coded with same code as the PAARS data element and Stat Master outpatient visit activity record.
Residence City Name	The name of the city or town where the individual resides.
Residence State Name	The name of the state where the individual resides.
Residence Street Name	Street name, including street direction and apt. designation, of usual or permanent address.
Residence Street No.	Residence Street No. of usual or permanent address.
Residence Zip Code	Zip code of patient's usual or permanent address. (99997=NA, 99998=Unknown, 99999=Missing)
Service Event	The code used to designate a service event category during an episode of care (admission, discharge, visit, etc.).

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Service Event Charge Amount	The amount charged to a patient for medical services delivered during a service event.
Service Event Date	The date of occurrence of a service event during an episode of acute care. [MMDDCCYY]
Service Setting Code	The code used to designate a provider service setting.
Service Unit Code	The code used to designate the type of unit of medical service.
Service Unit Quantity	The number of units of service provided during an incident of medical service.
Sex	The code used to designate gender. (2=Female, 1=Male, 0=Unknown)
Social Security No.	The patient's social security number.
Source of Income	The code used to designate the primary or largest single source of family income.
Source of Payment	The code indicating the source of payment for all or a portion of the patient's bill One for each amount paid.
TPS#	Trauma Patient Summary Number This field is an eight (8) digit alphanumeric code assigned to trauma patients treated at designated trauma hospitals.
Type of Employment	The code used to designate the occupation of the patient's family's primary wage earner.
Type of Outpatient Service	The code used to designate different outpatient service category by the care rendered or the specialty of the provider (e.g., clinic code, medical service, etc.)

ATTACHMENT A-14

MICRS – CODE TABLE

TABLE NAME	CODE
CITY CODE	Attach to a separate table (LACounty city codes).
CLINIC CODE	Attach to a separate CLNIC code table.
CPT	Attach to separate CPT CODE table (code file has 7.146 records).
ER DISPOSITION	0 NOT APPLICABLE 1 RELEASE 2 TRANSFER TO ANOTHER HOSPITAL 3 ADMISSION 4 DEATH
ER FLAG	0 NOT AN EMERGENCY VISIT 1 ER/NON-EMERGENCY VISIT 2 ER/EMERGENCY VISIT
HIV	0 Non-HIV positive or undetermined 1 HIV positive
ICD	Attach to separate ICD CODE table.
OUTPATIENT SERVICES	0 UNKNOWN 1 PRIMARY CARE 2 SPECIALTY CARE 3 HOME HEALTH CARE 4 DENTAL CARE 5 LABORATORY 6 MEDICAL SUPPLIES 7 OPTOMETRY 8 PHARMACY 9 PODIATRY 10 DETOXIFICATION 11 RADIOLOGY 12 AMBULATORY SURGERY 13 OTHER (RESIDENCY)

TABLE NAME	CODE	
PAYER SUMMARY	Attach to a separate table.	
PROVIDER RELATIONSHIP	0	UNKNOWN
	1	COUNTY HOSPITAL
	2	CONTRACT HOSPITAL
	3	UNIVERSITY TEACHING HOSPITAL
	4	OTHER NON-CONTRACT HOSPITAL
PROVIDER SUMMARY	Attach to a separate table.	
RECE/ETHNICITY	0	UNKNOWN
	1	WHITE
	3	BLACK
	5	HISPANIC/SPANISH SURNAME
	6	NATIVE AMERICAN/ESKMO/ALEUT
	7	ASIAN/PACIFIC ISLANDERS
	8	FILIPINO
	9	OTHER
	0	UNKNOWN
REC-SOURCE [Discretionary]	1	Non-County Hospitals (EMS – CRSIS)
	2	County Hospitals
	3	Non-County Hospitals (EMS – LANCET) [Discretionary]
	4	Non-County Physicians (CPO) [Discretionary]
	5	HCOIS (PHP&S and West Hollywood Clinic)
	6	PHP&S (Compucare)
	7	AIDS Program Office (APO)
	9	Non-County Physicians (CPO) [Non-Discretionary]
	10	Non-County Hospitals (EMS – CRSIS) [Non-Discretionary)
	11	Non-County Hospitals (EMS – LANCET) [Non-Discretionary)
	12	PHP&S (Health Centers/Utilization Data)
REFERRAL CODE	Attach to separate REFERRAL CODE file.	

TABLE NAME	CODE	
SERVICE EVENTS	0	UNKNOWN
	1	ADMISSION
	2	DISCHARGE
	3	TRANSFER IN
	4	TRANFER OUT
	5	DEATH
	6	BIRTH
	7	RELEASE
	8	VISIT
SERVICE SETTINGS	0	UNKNOWN
	1	HOSPITAL INPATIENT
	2	HOSPITAL EMERGENCY ROOM
	3	HOSPITAL OUTPATIENT
	4	COMPREHENSIVE HEALTH CENTER
	5	HEALTH CENTER
	6	FREE STANDING CLINIC
	7	PHYSICIAN OFFICE
	8	INPATIENT MENTAL HEALTH
	9	INPATIENT REHABILITATION
	10	SKILLED NURSING FACILITY
	11	INTERMEDIATE CARE FACILITY
	12	AMBULANCE
	13	HOME HEALTH CARE
	14	DENTAL
	15	RESIDENTIAL
SERVICE UNITS	0	NOT APPLICABLE
	1	DAY
	2	VISIT
	3	TEST
	4	IMAGE
	5	PRESCRIPTION
	6	SESSION
	7	EPISODE
	8	HOUR
	9	CASE EVALUATION
	10	DURABLE MEDICAL SUPPLES

TABLE NAME	CODE	
SEX	0	UNKNOWN
	1	MALE
	2	FEMALE
SOURCE OF INCOME	0	UNKNOWN
	1	SELF EMPLOYED
	2	DISABILITY
	3	RETIREMENT
	4	PUBLIC ASSISTANCE
	5	OTHER e.g. V. A. benefits, interest, dividends, rent, child support, attorney, etc.
	6	Wages
	9	NONE
SOURCE OF PAYMENT	0	UNKNOWN
	1	SELF-PAY
	2	PRIVATE INSURANCE
	3	MEDICARE
	4	MEDI-CAL
	5	CHIP/RHS
	6	MISP
	7	OTHER SECTION 17000
	8	OTHER/DONATION
STATUS-CODE	1	PRIMARY (Principal)
	2	OTHER
TYPE OF EMPLOYMENT	0	UNKNOWN
	1	FARMING, FORESTRY, FISHING
	2	PRODUCTION, INSPECTION, REPAIR, CRAFT, HANDLERS, HELPERS, LABORERS, TRANSPORTATION
	3	SERVICES, SALES
	4	EXECUTIVE, ADMINISTRATIVE, MANAGERIAL, PROFESSIONAL, TECHNICAL AND RELATED SUPPORT
	5	OTHER
	6	UNEMPLOYED

EXHIBIT B

PPP PROGRAM
CLAIMS ADJUDICATION SERVICES
STATEMENT OF WORK

1. Definition:

A. Claims Adjudication Services: Claims adjudication services of PPP Program claims, include receipt, review, and approval for reimbursement for each PPP claim submitted by PPP Providers for eligible primary care, specialty, dental, and any related pharmaceutical services rendered to eligible indigent patients. These services shall be provided according to PPP policies, procedures, and instructions, which are subject to revision from time to time. For purposes of this Agreement, a claim includes a Form CMS-1500 (formerly known as Health Care Financing Administration ("HCFA") 1500 Form), Attachment B-1, or a Uniform Billing ("UB-92") Form, Attachment B-2, and other forms that may be approved by the County.

B. Adjudicated: As used herein, the term "adjudicated" shall mean the process by which the reimbursement rate is determined, according to PPP Program policies and procedures.

C. Denied: As used herein, the term "denied" shall mean a claim or medical procedure that has been adjudicated

according to program policies and procedures and found not to be payable.

D. Electronic Claim: As used herein, the term "electronic claim" shall mean a claim that is submitted to the Contractor electronically, on a disk, or some other form of computer media by PPP Program Providers for reimbursement for medical services rendered to PPP Program eligible indigent patients.

E. Contract Year ("CY"): As used herein, the term " contract year" shall mean the twelve (12) month period March 31st of the applicable year.

F. Fiscal Year ("FY"): As used herein, the term "fiscal year" shall mean the twelve (12) month period beginning July 1st of a year and ending June 30th of the following year.

G. Hard Copy Claim: As used herein, the term "hard copy claim" shall mean a claim that is submitted to Contractor on paper (hard-copy Form CMS-1500 or UB92 Form claim forms) by PPP Program Providers for reimbursement for medical services rendered to eligible indigent patients.

H. On-line Access: As used herein, the term "on-line access" shall mean the electronic linkage of Contractor's system to County personal computers ("PCs")

located at County specified sites (minimum of two (2)) which permit County access to the PPP Program Provider Database and PPP Program Database.

2. Contractor Personnel:

A. Contractor shall designate a Project Manager to lead and coordinate Contractor's claims processing services hereunder.

B. Notwithstanding any representation by County regarding the participation of County personnel in any phase of this project, Contractor assumes sole responsibility for the timely accomplishment of all activities described herein.

3. County Personnel: Director, Office of Ambulatory Care, shall be designated as the County Project Manager (CPM) for activities hereunder, unless otherwise determined by ~~County~~ Director.

County personnel will be made available to Contractor at the sole-discretion of CPM to provide necessary input and assistance in order to answer questions and provide necessary liaison activities between Contractor and County departments. The word "County" or "Director" shall be deemed to refer to the CPM.

4. Services To Be Provided: Services to be provided within thirty (30) calendar days of Board of Supervisors' approval include, but shall not be limited to:

A. Contractor shall process hard copy and electronic PPP Program claims for reimbursement of contract medical services (i.e., primary, specialty, dental, and related pharmaceutical services, if any) using an on-line claims processing system and line-item and/or on-line adjudication pursuant to PPP Program contract requirements.

B. Contractor's on-line claims review and processing procedures must include, but not be limited to, the following:

1) Sorting claims.

2) Date-stamping (i.e., Month/Date/Year) all claims upon receipt at the time of the original submission and at the time of any subsequent resubmission.

3) Reviewing claims for completeness and accuracy based on the billing instructions developed by County.

4) Rejecting claim if it is incomplete or inaccurate and return to the submitting PPP provider within ten (10) working days of claim receipt date,

with a Director approved form letter, stating the problem with the claim and the procedures for resubmission, or as may otherwise be agreed to by Director and Contractor. Enter the reason for rejection, claim receipt date, PPP provider's name and tax ID number, patient's name, date of service, and service location on Contractor's system.

5) Entering all claim information and all specified data elements (as requested on the Form CMS-1500 or the UB92 forms) into the system for all complete claims for each submission deadline per billing instructions.

Contractor will deliver one (1) set of the RA to Director for the files. Contractor shall provide mailing services, i.e., address, stuff, and seal envelopes, and mail the RAs and the warrants, including the RAs for denied claims, to PPP providers. The Director will reimburse Contractor $0.015 per claim and the postage costs associated with the mailing.

6) Matching Medi-Cal Eligible History File and Data Matching Elements: Each month after receipt of the Medi-Cal eligibility history file for the previous

month, Contractor shall reconcile the patient information data for the two (2) previous RAs against the Medi-Cal eligibility history file and identify, within ten (10) workings days, Medi-Cal eligible and non-eligible claims at no additional cost to County. Contractor shall provide County and PPP Partners with:

a) Retro Medi-Cal RA indicating eligible Medi-Cal claims and Medi-Cal numbers; and

b) The next check register which shall indicate amount due to County or PPP Partner.

Contractor shall be responsible to match the following specified Partner claim data elements, if present, against the Medi-Cal Eligibility History File:

- Name
- Date of Birth
- Gender
- Social Security Number (SSN), if present
- Service date

Contractor recognizes that the County format may change from time to time as a result of changing requirements or needs. At County's option, Contractor

shall include or delete County specified matching data elements.

Contactor shall provide an electronic data listing of Medi-Cal eligible patient information if requested by the Director.

7) Contractor shall provide Director a list of canceled claims after Contractor has canceled the claims (e.g., if the claim has been erroneously paid or if the PPP Provider receives a payment from the patient or third-party payor, after the claim has been paid).

8) Flag all incomplete, erroneous, or duplicate claims.

9) Reflecting line-item denials.

10) Validate procedure and diagnosis codes.

11) Automatic/manual assignment of a unique claim number.

12) Audits and quality assurance sampling.

13) Claims reporting.

14) Other claim edits, as may be required by Director from time to time.

15) Establish and maintain a separate and unique PPP Provider Database and PPP Program Database for each FY of the Agreement.

a) The PPP Program Database incorporates all data elements necessary for all PPP Program related work, including, but not limited to, preparing reports, providing Medically Indigent Care Reporting System ("MICRS") data, and as otherwise described in this Exhibit and Attachments.

b) The PPP Provider Database shall incorporate all data elements described in this Exhibit and Attachments. Contractor shall regularly update the PPP Providers Database to ensure that PPP Provider information, as requested on the PPP Provider Enrollment Form, is readily available to Director. Current PPP Provider information in the PPP Provider Database may only be updated with a written notice from PPP Provider.

c) Contractor shall provide Director with a copy of the PPP Program Database within ten (10) working days following the end of the month.

16) Provide system connectivity to two (2) County specified work stations to be designated by Director. Contractor shall also provide the capability to access both the PPP Program Database and PPP Provider Database. Contractor shall provide the capability for County's personal computers, linked to Contractor's system, to have inquiry capability and to request manipulation of any and all data elements in the PPP Program Database and PPP Provider Database and download the results and/or summary of such manipulation as an ASCII file onto County's personal computers. If requested by Director, Contractor shall provide three (3) days of formal training for County on-line users and assistance as necessary during the term of the Agreement. Director will select the two (2) persons for which training will be provided.

In the event that special hardware is necessary in order to access the Contractor's system or to link County's two (2) work stations to Contractor's system, Contractor shall provide such hardware including software for County's use. Contractor shall install and maintain all hardware including software provided to County herein.

17) Develop, maintain, and provide detailed written instructions for PPP Provider submission of electronic claims, as approved by Director. As needed or requested by Director, Contractor shall have workshops for County staff, PPP Providers, and PPP Provider billing groups to support electronic claim submission.

18) Provide and manage a telephone hot line for PPP providers to inquire on the status of claims. Questions regarding the PPP Program or policy and procedures issues shall be referred to Director. Upon PPP provider request, Contractor will send out the Director's approved billing instructions. The hot line must be staffed from 8:00 a.m. to 4:30 p.m. Pacific Standard Time, Monday through Friday, except County holidays. At a minimum, the hot line shall have voice mail or other message capabilities to receive calls during non-operation hours. Except for holidays and weekends, calls shall be returned within 24 hours. A log of all calls must be maintained and shall include, but shall not be limited to, the PPP provider's name, billing group name, caller's name, claim number, date and time of call, a brief summary

of the purpose and disposition of the call, and name of person who took the call. This log shall be made available to Director upon request at all reasonable times, for review and for photocopying.

19) Prepare written materials for review and approval by Director prior to distribution (address, stuff, and seal envelopes) and mail Director approved materials to PPP providers and deliver same to Director.

20) Develop and maintain a Backup System consisting of an electronic copy of the PPP Program Database, PPP Provider Database, and all other related data on CD or on other County specified computer media off-site. The PPP Program Database shall be backed up on a daily basis; the PPP Provider Database shall be backed up whenever a change occurs, including an addition or deletion of fields, a provider address change, etc. In the event that Contractor's system becomes inoperative, Director and Contractor shall mutually agree on a reasonable time frame to resume processing PPP claims.

C. Provide MICRS data according to County specifications, as specified in Attachments B-3 to B-9.

5. Additional Requirements: In performing the services hereinabove, Contractor shall:

A. Perform at all times in a professional and businesslike manner when assisting PPP providers and answering PPP providers' questions.

B. Employ industry standards to ensure appropriate payments to PPP providers under the PPP Program.

C. Respect the confidential nature of all information with regard to PPP provider patient records and PPP Program financial records. Contractor acknowledges the confidentiality of all PPP provider patient data and, therefore, shall obtain/extract only that information needed to meet claims processing and adjudication requirements. All such collected information shall become the property of County upon the termination of this Agreement, unless otherwise agreed to by Director.

D. Prepare all correspondence to PPP providers in a professional and businesslike manner; no correspondence may be hand written and all correspondence to PPP providers must be approved by Director in writing prior to sending, unless otherwise directed by Director.

6. Access to information: In order for Contractor to provide the services described in this Exhibit, Director shall

provide Contractor necessary and pertinent PPP information, including operational/administrative records, and statistics.

Contractor shall return all the material provided by Director, upon his/her request, including but not limited to, PPP Program Database data files, PPP Provider Database files, PPP provider patient records/data, PPP Program financial records, all information incidental to contract administration, all completed work, all PPP Program data, all MICRS data, in the same condition and sequence in which received within thirty (30) calendar days from date of request.

7. Reports: Contractor shall provide financial, management, and ad-hoc reports (refer to Attachment B-9, Sample Reports), as requested by Director.

Claim management reports shall be submitted to Director and shall include, but not be limited to, the following:

1. Summary visits reports by clinic (Bi-monthly report with amounts of various payment categories;
2. P89 and P95 (Monthly reports to include the number of claims and amount paid by month of service);
3. Check Register (Bi-monthly summary reports regarding payment/status of claim);
4. RA Reports; and
5. Ad-hoc reports.

As each month of claims processing services is completed, the monthly reports describing that month's claim activity is to

be submitted to Director within ten (10) working days following the end of that completed month. Contractor shall provide analysis and interpretation of reports, as needed.

Contractor shall prepare all the necessary reconciliation reports (monthly, quarterly, biannually, yearly, or as otherwise requested by Director) for each FY and make any and all necessary adjustments to PPP Program Database. Contractor shall re-adjudicate PPP claims, as may be deemed necessary by Director, at no additional per-claim cost to County when it has been determined that the Contractor made an error. If County has made an error and the PPP claim requires re-adjudicating, County will be charged for programming and re-adjudicating the claim. Director and Contractor shall mutually work to ensure that County's records and Contractor's PPP Program Database are fully reconciled. Each FY shall be fully and completely reconciled as determined by Director.

8. Records and Audits: Subject to the conditions and terms set forth in the body of Agreement, Contractor agrees to make all billing and eligibility records available upon request, during normal business hours, to County and authorized State and federal representatives, for purposes of inspection, audit, and copying. Contractor may use microfilm or other media for purposes of maintaining hard copy claim files. Contractor shall

provide to Director such material in County specified electronic data format and on specified computer media.

9. Quality Improvement: Contractor shall provide to Director a written description of the quality control and claim management procedures employed by Contractor to process and adjudicate PPP Program claims.

Quality control and claim management procedures shall include, but are not limited to, appropriate claim edits to ensure record accuracy (e.g., eligibility validation, flagging of duplicate billings), and audit trails to substantiate all adjudicated claim payment authorizations.

Director may periodically sample Contractor's work and request Contractor to provide an audit of its internal claims processing/adjudication procedures in order to determine the accuracy of Contractor's claims processing/adjudication practices. Should any work be inaccurate, as determined by Director, Director will notify Contractor within a reasonable period of time of such findings. Contractor shall correct any and all inaccuracies within ten (10) working days of receipt of notice of any errors and such correction shall be at no additional cost to County. In the event that Director finds that the errors have not been corrected by Contractor, the cycle of corrective action by Contractor and re-sampling by Director

may, at Director's sole discretion, be repeated. Director will notify Contractor within a reasonable period of time of the re-sampling results.

10. Payment: The sole compensation to Contractor for services provided hereunder shall be as follows:

A. For Primary Care Medical Services:

1) Set up Fees: Contractor shall not receive a set up fee.

2) Adjudication Fees:

a) For each hard copy primary care service claim adjudicated that either results in a denial or payment to a PPP provider, Contractor shall receive a fee of $2.35.

b) For each electronic primary care service claim adjudicated that results in a denial or payment to a PPP provider, Contractor shall receive a fee of $1.35.

B. For Specialty and Dental Care Services:

1) Set up Fees: Contractor shall not receive a set up fee.

2) Adjudication Fees:

a) For each hard copy specialty or dental service claim adjudicated that either results in

a denial or payment to a PPP provider, Contractor shall receive a fee of $2.60 per claim.

b) For each electronic specialty or dental service claim adjudicated that results in a denial or payment to a PPP Partner, Contractor shall receive a fee of $1.85 per claim.

c) For each related hard copy pharmaceutical claim adjudicated, Contractor shall receive a fee of $1.85.

d) For each electronic pharmaceutical claim adjudicated that results in a denial or payment to a PPP Partner, Contractor shall receive a fee of $1.35 per claim.

C. Mailing Services: Contractor shall receive a fee of $0.015 per claim and the actual cost of postage associated with the mailing described in Paragraph 4, Services To Be Provided, Subparagraph B, 5, c of this Exhibit.

D. Medically Indigent Care Reporting System (MICRS) Reporting: Contractor shall not receive reimbursement for reporting.

E. Systems Modifications: Contractor shall receive a fee of Eighty Dollars ($80) per programming hour or

prorated portion thereof for periods less than one hour for revised or new programming requested by County. The process which the parties will use is as follows:

1) Contractor shall submit to Director a quotation in writing for the projected work, including an estimated number of programmer hours for completion of the programming task.

2) Director shall determine the credibility of the estimate submitted by Contractor and, if necessary, revise the estimated number of hours requested for performing the programming task. Director shall apprise Contractor in writing of Director's acceptance of the quotation or of the revised estimate within ten (10) calendar days of the Director's receipt of the quotation.

3) Upon completion of the work, Contractor shall submit an invoice to County with the actual number of hours that was required to complete the programming task, not to exceed, however, the number of hours for completion of the task as approved by County. Contractor shall keep detailed records of staff work and time spent on any programming task

hereunder, and shall make them available for audit and photocopying upon request by Director.

F. Invoices: Contractor shall submit a monthly invoice, in arrears, showing all claims processed and adjudicated claims and the costs for mailing services for the previous month of service. County shall only pay for claims that have completed the adjudication process, i.e., an RA has been issued. County shall reimburse Contractor for each adjudicated claim. County shall pay all invoices within thirty (30) calendar days from receipt of complete and correct billing, as determined by County.

In the event that Director requires Contractor to re-adjudicate any and all claims due to the year end reconciliation process, no additional per claim cost shall be due Contractor.

G. Accuracy of Work: Corrections of any and all claims due to Contractor's errors, as determined by County, shall be performed at no cost to County. County may periodically sample the work to determine the accuracy of processing. County's Project Manager will provide written notice to Contractor within a reasonable period of time of any claims processing services work which is not acceptable to County. Contractor shall promptly correct all

inaccurate or unacceptable work to conform to the requirements of this Exhibit and Attachments at no additional cost to County. County may withhold fifteen percent (15%) of Contractor's invoice amount until all claims processing services work for that billing cycle is acceptable to County.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

ATTACHMENT B-2

APPROVED OMB NO. 0938-0279

ST 11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a												A
b												B
												C

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								
2								
3								
4								
5								
6								
7								
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20								
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	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A							
B							
C							

57	DUE FROM PATIENT ▶

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A					
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
	C		D		E		A

a	84 REMARKS	OTHER PHYS. ID
b		B
c		85 PROVIDER REPRESENTATIVE 86 DATE

ATTACHMENT B-3

PUBLIC/PRIVATE PARTNERSHIP (PPP) PROGRAM

MEDICALLY INDIGENT CARE REPORTING SYSTEM (MICRS)

STATEMENT OF WORK

I. GENERAL SCOPE OF WORK

CONTRACTOR shall fully perform, complete and deliver on time all work, deliverables and/or other items, however denoted, as set forth below and in documents attached and referenced herein, in full compliance with the requirements of this Statement of Work.

The general responsibilities of CONTRACTOR under this Agreement shall include, but not be limited to, all labor required to establish data base(s) in order to meet State Department of Health Services ("STATE") and County of Los Angeles ("COUNTY") Public/Private Partnership ("PPP") Program reporting requirements, produce STATE required data and submit to COUNTY, as described herein and in Attachment B-4 (MICRS Record Lay-Out), Attachment B-5 (MICRS Code Tables), and Attachment B-6 (MICRS Field Description).

CONTRACTOR will also provide test data for MICRS to ensure that the record layout and format are consistent with program requirements. The test data are due thirty (30) calendar days after adjudication of the first forty (40) PPP claims.

II. BACKGROUND AND OVERVIEW

AB 75 and subsequent legislation implementing the Tobacco Tax and Health Protection Act of 1988 require all counties to report health care costs, utilization and patient demographic data to the STATE. As a result, the STATE has mandated that COUNTY report the required data by establishing the Medically Indigent Care Reporting System (MICRS) beginning with Fiscal Year 1991-92 and on-going.

This Statement of Work describes the services required of CONTRACTOR to provide data elements from PPP reimbursement claims to the COUNTY in order to meet STATE reporting requirements. The following are procedures for the timely submission of data to COUNTY.

III. PROJECT MANAGEMENT

The County of Los Angeles Department of Health Services (DHS) Project Manager shall administer the contract and ensure that CONTRACTOR meets or exceeds the contract requirements. The project coordination between CONTRACTOR and COUNTY shall be through the COUNTY's MICRS Project Manager, unless otherwise designated by Director.

IV. DATA REQUIREMENTS AND SUBMISSION PROCEDURES

A. DATA REQUIREMENTS

CONTRACTOR shall prepare MICRS data in the required format, and informational/data requests on an ad-hoc basis. CONTRACTOR shall provide a CD copy, or via a secure electronic data transfer (i.e. ftp - file transfer protocol), of the PPP Partner Database as described herein and in Attachment B-7 (Provider Profile).

- MICRS Data Requirements

CONTRACTOR will be responsible to collect and maintain current information on PPP providers as well as provide the patient utilization information as described in Attachment B-4 (MICRS Record Layout), Attachment B-5 (MICRS Code Tables), and Attachment B-6 (MICRS Field Description).

B. DATA SUBMISSION PROCEDURES

- MICRS Data Submission Procedures

CONTRACTOR shall prepare and submit via email MICRS data to the Department of Health Services, Health Services Administration, Attention: MICRS Unit.

CONTRACTOR shall format the data according to the record lay-out requirements described herein and submit the data in a fixed block, ASCII format. The data will be submitted on computer media CD or via email, or via a secure electronic data transfer (i.e. ftp – file transfer protocol). CONTRACTOR shall recognize that COUNTY data format requirements may change from time to time as a result of STATE program requirements or COUNTY information requirements, and CONTRACTOR must be able to adjust accordingly.

CONTRACTOR is responsible to ensure that the data are correctly identified, appropriately labeled, and loaded on CD, or transmitted via a secure electronic data transfer (i.e. ftp – file transfer protocol).

COUNTY shall inspect and review MICRS data provided by CONTRACTOR and reject all improperly formatted or unreadable data within ten (10) work days after receipt thereof CONTRACTOR shall correct such data without additional cost to COUNTY.

V. REIMBURSEMENT

CONTRACTOR shall not be reimbursed by COUNTY for services not described herein.

ATTACHMENT B-4

MICRS RECORD LAYOUT

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION
Data Layout

MICRS Record Set: PPP: PRIMARY, SPECIALTY, AND GENERAL RELIEF CLAIM

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	COMMENT
(1) PATIENT LAST NAME	1	20	20	LEFT/ALPHANUMERIC	YES	
(2) PATIENT FIRST NAME	21	35	15	LEFT/ALPHANUMERIC	YES	
(3) PATIENT MIDDLE NAME	36	50	15	LEFT/ALPHANUMERIC	YES	
(4) DATE OF BIRTH	51	58	8	DATE	YES	FORMAT: MMDDCCYY
(5) SEX	59	59	1	LEFT/ALPHANUMERIC	YES	
(6) RACE/ETHNICITY	60	60	1	LEFT/ALPHANUMERIC	YES	
(7) PATIENT MARITAL STATUS	61	61	1	LEFT/ALPHANUMERIC	NO	
(8) PRIMARY LANGUAGE CODE	62	63	2	LEFT/ALPHANUMERIC	YES	
(9) PERMANENT FILE NUMBER (MRUN)	64	72	9	LEFT/ALPHANUMERIC	NO	
(10) PATIENT ACCOUNT NUMBER	73	86	14	LEFT/ALPHANUMERIC	YES	
(11) MOTHER MAIDEN NAME	87	106	20	LEFT/ALPHANUMERIC	NO	
(12) MOTHER FIRST NAME	107	121	15	LEFT/ALPHANUMERIC	NO	
(13) FATHER LAST NAME	122	141	20	LEFT/ALPHANUMERIC	NO	
(14) FATHER FIRST NAME	142	156	15	LEFT/ALPHANUMERIC	NO	
(15) SOCIAL SECURITY NUMBER	157	166	10	LEFT/ALPHANUMERIC	YES	
(16) MEDI - CAL IDENTIFICATION NUMBER	167	181	15	LEFT/ALPHANUMERIC	YES	
(17) PATIENT ADDRESS	182	216	35	LEFT/ALPHANUMERIC	YES	
(18) PATIENT CITY	217	236	20	LEFT/ALPHANUMERIC	YES	
(19) PATIENT STATE	237	238	2	LEFT/ALPHANUMERIC	YES	
(20) PATIENT ZIP	239	243	5	LEFT/ALPHANUMERIC	YES	When Patient Zip Code = '99999' then Patient Address is not known, per AIA.
(21) PATIENT BIRTH PLACE	244	263	20	LEFT/ALPHANUMERIC	NO	
(22) FAMILY SIZE	264	265	2	RIGHT/NUMERIC	NO	
(23) MONTHLY INCOME	266	272	7	RIGHT/NUMERIC	NO	
(24) SOURCE OF INCOME	273	273	1	LEFT/ALPHANUMERIC	NO	
(25) TYPE OF EMPLOYEMENT	274	274	1	LEFT/ALPHANUMERIC	NO	
(26) SERVICE SETTING CODE	275	276	2	LEFT/ALPHANUMERIC	YES	

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION
Data Layout

MICRS Record Set: PPP: PRIMARY, SPECIALTY, AND GENERAL RELIEF CLAIM

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	COMMENT
(27) SERVICE UNITS CODE	277	278	2	LEFT/ALPHANUMERIC	YES	Default 2 for Visit, leading space
(28) SERVICE UNITS QUANTITY	279	282	4	LEFT/ALPHANUMERIC	YES	
(29) EMERGENCY ROOM PRIORITY FLAG	283	283	1	LEFT/ALPHANUMERIC	NO	
(30) DISCHARGE DISPOSITION CODE	284	285	2	LEFT/ALPHANUMERIC	YES	Default value "8" for Visit, then trailing space
(31) DISCHARGE DATE	286	293	8	DATE	YES	FORMAT: MMDDCCYY
(32) TYPE OF INPATIENT ADMISSION CODE	294	295	2	LEFT/ALPHANUMERIC	NO	
(33) ADMIT DATE	296	303	8	DATE	YES	FORMAT: MMDDCCYY
(34) DATE OF INITIAL CLINIC VISIT	304	311	8	DATE	NO	FORMAT: MMDDCCYY
(35) TYPE OF OUTPATIENT SERVICE	312	313	2	LEFT/ALPHANUMERIC	YES	
(36) CLINIC CODE	314	318	5	LEFT/ALPHANUMERIC	NO	
(37) ENCOUNTER CHARGE CODE	319	328	10	LEFT/ALPHANUMERIC	NO	
(38) TRAUMA PATIENT SEQUENCE NUMBER	329	336	8	LEFT/ALPHANUMERIC	NO	
(39) ENCOUNTER PATIENT SERVICE CODE	337	343	7	LEFT/ALPHANUMERIC	NO	
(40) NURSING UNIT	344	349	6	LEFT/ALPHANUMERIC	NO	
(41) REMITTANCE ADVICE DATE	350	357	8	DATE	YES	FORMAT: MMDDCCYY
(42) CURRENT CONDITION CODE	358	358	1	LEFT/ALPHANUMERIC	NO	
(43) FAMILY PLANNING INDICATOR	359	359	1	LEFT/ALPHANUMERIC	NO	
(44) ANCILLARY FLAG	360	360	1	LEFT/ALPHANUMERIC	YES	
(45) EPSDT INDICATOR	361	361	1	LEFT/ALPHANUMERIC	NO	
(46) SERVICE EVENT CHARGE AMOUNT	362	370	9	RIGHT/NUMERIC	YES	
(47) AMOUNT PAID	371	379	9	RIGHT/NUMERIC	YES	
(48) CLAIM NUMBER	380	394	15	LEFT/ALPHANUMERIC	YES	Not unique per patient. Based on the number of claims per patient
(49) CARRIER CODE/PRIMARY	395	397	3	LEFT/ALPHANUMERIC	NO	
(50) CARRIER CODE/SECONDARY	398	400	3	LEFT/ALPHANUMERIC	NO	
(51) CARRIER CODE/TERTIARY	401	403	3	LEFT/ALPHANUMERIC	NO	
(52) TOTAL ALLOWABLE AMOUNT	404	412	9	LEFT/ALPHANUMERIC	NO	

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION
Data Layout

MICRS Record Set: PPP: PRIMARY, SPECIALTY, AND GENERAL RELIEF CLAIM

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	COMMENT
(53) GENERAL RELIEF ID NUMBER	413	426	14	LEFT/ALPHANUMERIC	YES	
(54) FILLER	427	430	4	N/A	NO	
(55) FACILITY ID	431	439	9	LEFT/ALPHANUMERIC	YES	AIA sends the Facilities Tax ID. They stated that they distinguish multiple facilities with the same Tax ID by a Suffix, which has been added below.
(56) FACILITY ID SUFFIX	440	441	2	LEFT/ALPHANUMERIC	YES	AIA uses a one-character alpha value
(57) SOURCE OF ADMISSION	442	443	2	LEFT/ALPHANUMERIC	NO	
(58) RECORD SOURCE	444	445	2	LEFT/ALPHANUMERIC	YES	Default 21 for P/PP Dental, Default 19 for P/PP Primary, Default 20 for P/PP Specialty, Default 22 for P/PP Pharmacy, Default 30 for P/PP GR
(59) NAME OF OUTSIDE ANCILLARY PROVIDER	446	475	30	LEFT/ALPHANUMERIC	YES	
(60) ANCILLARY PROVIDER TAX ID NUMBER	476	495	20	LEFT/ALPHANUMERIC	YES	
(61) SOURCE OF REFERRAL	496	501	6	LEFT/ALPHANUMERIC	NO	
(62) COUNTY ID	502	510	9	LEFT/ALPHANUMERIC	YES	CHANGED AS OF 8-20-03 FROM ADMITTING PHYSICIAN LICENSE NUMBER TO COUNTY ID (AKA: SITEID)
(63) ATTENDING PHYSICIAN LICENSE NUMBER	511	519	9	LEFT/ALPHANUMERIC	NO	
(64) REFERRING PHYSICIAN LICENSE NUMBER	520	528	9	LEFT/ALPHANUMERIC	NO	
(65) OTHER PHYSICIAN LICENSE NUMBER	529	537	9	LEFT/ALPHANUMERIC	NO	
(66) DRG CODE	538	543	6	LEFT/ALPHANUMERIC	NO	
(67) PRINCIPAL DIAGNOSIS CODE	544	549	6	LEFT/ALPHANUMERIC	YES	
(68) ADMITTING DIAGNOSIS CODE	550	555	6	LEFT/ALPHANUMERIC	NO	
(69) EXTERNAL CAUSE CODE	556	561	6	LEFT/ALPHANUMERIC	NO	
(70) DISCHARGE DIAGNOSIS CODE	562	567	6	LEFT/ALPHANUMERIC	NO	
(71) UNIQUE DIAGNOSIS COUNTER	568	569	2	RIGHT/NUMERIC	YES	DEFAULT VALUE = "0"
(72) PROCEDURE CODING METHOD PRINCIPAL	570	570	1	RIGHT/NUMERIC	YES	
(73) PROCEDURE CODE PRINCIPAL	571	576	6	LEFT/ALPHANUMERIC	YES	
(74) PROCEDURE MODIFIER OR TOOTH PRINCIPAL	577	578	2	LEFT/ALPHANUMERIC	YES	
(75) PRIMARY VISIT CHARGE AMOUNT	579	588	10	RIGHT/NUMERIC	YES	

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION
Data Layout

MICRS Record Set: PPP: PRIMARY, SPECIALTY, AND GENERAL RELIEF CLAIM

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	COMMENT
(76) UNIQUE PROCEDURE COUNTER	589	591	3	RIGHT/NUMERIC	YES	
(80) PROCEDURE QUANTITY 1	592	593	2	RIGHT/NUMERIC	YES	
(81) PROCEDURE CODING METHOD 1	594	594	1	RIGHT/NUMERIC	YES	
(82) PROCEDURE CODE 1	595	600	6	LEFT/ALPHANUMERIC	YES	
(83) PROCEDURE MODIFIER 1	601	602	2	LEFT/ALPHANUMERIC	YES	
(84) PROCEDURE CHARGE AMOUNT 1	603	612	10	RIGHT/NUMERIC	YES	
(85) PROCEDURE QUANTITY 2	613	614	2	RIGHT/NUMERIC	YES	
(86) PROCEDURE CODING METHOD 2	615	615	1	RIGHT/NUMERIC	YES	
(87) PROCEDURE CODE 2	616	621	6	LEFT/ALPHANUMERIC	YES	
(88) PROCEDURE MODIFIER 2	622	623	2	LEFT/ALPHANUMERIC	YES	
(89) PROCEDURE CHARGE AMOUNT 2	624	633	10	RIGHT/NUMERIC	YES	
(90) PROCEDURE QUANTITY 3	634	635	2	RIGHT/NUMERIC	YES	
(91) PROCEDURE CODING METHOD 3	636	636	1	RIGHT/NUMERIC	YES	
(92) PROCEDURE CODE 3	637	642	6	LEFT/ALPHANUMERIC	YES	
(93) PROCEDURE MODIFIER 3	643	644	2	LEFT/ALPHANUMERIC	YES	
(94) PROCEDURE CHARGE AMOUNT 3	645	654	10	RIGHT/NUMERIC	YES	
(95) PROCEDURE QUANTITY 4	655	656	2	RIGHT/NUMERIC	YES	
(96) PROCEDURE CODING METHOD 4	657	657	1	RIGHT/NUMERIC	YES	
(97) PROCEDURE CODE 4	658	663	6	LEFT/ALPHANUMERIC	YES	
(98) PROCEDURE MODIFIER 4	664	665	2	LEFT/ALPHANUMERIC	YES	
(99) PROCEDURE CHARGE AMOUNT 4	666	675	10	RIGHT/NUMERIC	YES	
(100) PROCEDURE QUANTITY 5	676	677	2	RIGHT/NUMERIC	YES	
(101) PROCEDURE CODING METHOD 5	678	678	1	RIGHT/NUMERIC	YES	
(102) PROCEDURE CODE 5	679	684	6	LEFT/ALPHANUMERIC	YES	
(103) PROCEDURE MODIFIER 5	685	686	2	LEFT/ALPHANUMERIC	YES	
(104) PROCEDURE CHARGE AMOUNT 5	687	696	10	RIGHT/NUMERIC	YES	

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION
Data Layout

MICRS Record Set: PPP: PRIMARY, SPECIALTY, AND GENERAL RELIEF CLAIM

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	COMMENT
(105) PROCEDURE QUANTITY 6	697	698	2	RIGHT/NUMERIC	YES	
(106) PROCEDURE CODING METHOD 6	699	699	1	RIGHT/NUMERIC	YES	
(107) PROCEDURE CODE 6	700	705	6	LEFT/ALPHANUMERIC	YES	
(108) PROCEDURE MODIFIER 6	706	707	2	LEFT/ALPHANUMERIC	YES	
(109) PROCEDURE CHARGE AMOUNT 6	708	717	10	RIGHT/NUMERIC	YES	
(110) PROCEDURE QUANTITY 7	718	719	2	RIGHT/NUMERIC	YES	
(111) PROCEDURE CODING METHOD 7	720	720	1	RIGHT/NUMERIC	YES	
(112) PROCEDURE CODE 7	721	726	6	LEFT/ALPHANUMERIC	YES	
(113) PROCEDURE MODIFIER 7	727	728	2	LEFT/ALPHANUMERIC	YES	
(114) PROCEDURE CHARGE AMOUNT 7	729	738	10	RIGHT/NUMERIC	YES	
(115) PROCEDURE QUANTITY 8	739	740	2	RIGHT/NUMERIC	YES	
(116) PROCEDURE CODING METHOD 8	741	741	1	RIGHT/NUMERIC	YES	
(117) PROCEDURE CODE 8	742	747	6	LEFT/ALPHANUMERIC	YES	
(118) PROCEDURE MODIFIER 8	748	749	2	LEFT/ALPHANUMERIC	YES	
(119) PROCEDURE CHARGE AMOUNT 8	750	759	10	RIGHT/NUMERIC	YES	
(120) PROCEDURE QUANTITY 9	760	761	2	RIGHT/NUMERIC	YES	
(121) PROCEDURE CODING METHOD 9	762	762	1	RIGHT/NUMERIC	YES	
(122) PROCEDURE CODE 9	763	768	6	LEFT/ALPHANUMERIC	YES	
(123) PROCEDURE MODIFIER 9	769	770	2	LEFT/ALPHANUMERIC	YES	
(124) PROCEDURE CHARGE AMOUNT 9	771	780	10	RIGHT/NUMERIC	YES	
(125) PROCEDURE QUANTITY 10	781	782	2	RIGHT/NUMERIC	YES	
(126) PROCEDURE CODING METHOD 10	783	783	1	RIGHT/NUMERIC	YES	
(127) PROCEDURE CODE 10	784	789	6	LEFT/ALPHANUMERIC	YES	
(128) PROCEDURE MODIFIER 10	790	791	2	LEFT/ALPHANUMERIC	YES	
(129) PROCEDURE CHARGE AMOUNT 10	792	801	10	RIGHT/NUMERIC	YES	
(130) PROCEDURE QUANTITY 11	802	803	2	RIGHT/NUMERIC	YES	

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES ADMINISTRATION
Data Layout

MICRS Record Set: PPP: PRIMARY, SPECIALTY, AND GENERAL RELIEF CLAIM

DATA ELEMENT Number/Name	FROM	TO	BYTE	JUSTIFY	AVAILABLE	COMMENT
(131) PROCEDURE CODING METHOD 11	804	804	1	RIGHT/NUMERIC	YES	
(132) PROCEDURE CODE 11	805	810	6	LEFT/ALPHANUMERIC	YES	
(133) PROCEDURE MODIFIER 11	811	812	2	LEFT/ALPHANUMERIC	YES	
(134) PROCEDURE CHARGE AMOUNT 11	813	822	10	RIGHT/NUMERIC	YES	
(135) PROCEDURE QUANTITY 12	823	824	2	RIGHT/NUMERIC	YES	
(136) PROCEDURE CODING METHOD 12	825	825	1	RIGHT/NUMERIC	YES	
(137) PROCEDURE CODE 12	826	831	6	LEFT/ALPHANUMERIC	YES	
(138) PROCEDURE MODIFIER 12	832	833	2	LEFT/ALPHANUMERIC	YES	
(139) PROCEDURE CHARGE AMOUNT 12	834	843	10	RIGHT/NUMERIC	YES	
(140) PROCEDURE QUANTITY 13	844	845	2	RIGHT/NUMERIC	YES	
(141) PROCEDURE CODING METHOD 13	846	846	1	RIGHT/NUMERIC	YES	
(142) PROCEDURE CODE 13	847	852	6	LEFT/ALPHANUMERIC	YES	
(143) PROCEDURE MODIFIER 13	853	854	2	LEFT/ALPHANUMERIC	YES	
(144) PROCEDURE CHARGE AMOUNT 13	855	864	10	RIGHT/NUMERIC	YES	
(145) INPATIENT CHARGE COUNTER	865	865	1	LEFT/ALPHANUMERIC	YES	
(146) CANCELLATION DATE	866	873	8	DATE	YES	
(147) REFUND/CANCELLED	874	874	1	RIGHT/NUMERIC	YES	VALUES ARE "R" FOR PARTIAL REFUND AND "C" CANCELLED CLAIM

Source: DHS4/AIA_DEV Schema

ATTACHMENT B-5

MICRS – CODE TABLE

TABLE NAME	CODE
CITY CODE	Attach to a separate table (LACounty city codes).
CLINIC CODE	Attach to a separate CLNIC code table.
CPT	Attach to separate CPT CODE table (code file has 7.146 records).
ER DISPOSITION	0 NOT APPLICABLE 1 RELEASE 2 TRANSFER TO ANOTHER HOSPITAL 3 ADMISSION 4 DEATH
ER FLAG	0 NOT AN EMERGENCY VISIT 1 ER/NON-EMERGENCY VISIT 2 ER/EMERGENCY VISIT
HIV	0 Non-HIV positive or undetermined 1 HIV positive
ICD	Attach to separate ICD CODE table.
OUTPATIENT SERVICES	0 UNKNOWN 1 PRIMARY CARE 2 SPECIALTY CARE 3 HOME HEALTH CARE 4 DEMTAL CARE 5 LABORATORY 6 MEDICAL SUPPLIES 7 OPTOMETRY 8 PHARMACY 9 PODIATRY 10 DETOXIFICATION 11 RADIOLOGY 12 AMBULATORY SURGERY 13 OTHER (RESIDENCY)

TABLE NAME	CODE	
PAYER SUMMARY	Attach to a separate table.	
PROVIDER RELATIONSHIP	0	UNKNOWN
	1	COUNTY HOSPITAL
	2	CONTRACT HOSPITAL
	3	UNIVERSITY TEACHING HOSPITAL
	4	OTHER NON-CONTRACT HOSPITAL
PROVIDER SUMMARY	Attach to a separate table.	
RECE/ETHNICITY	0	UNKNOWN
	1	WHITE
	3	BLACK
	5	HISPANIC/SPANISH SURNAME
	6	NATIVE AMERICAN/ESKMO/ALEUT
	7	ASIAN/PACIFIC ISLANDERS
	8	FILIPINO
	9	OTHER
	0	UNKNOWN
REC-SOURCE	1	Non-County Hospitals (EMS – CRSIS) [Discretionary]
	2	County Hospitals
	3	Non-County Hospitals (EMS – LANCET) [Discretionary]
	4	Non-County Physicians (CPO) [Discretionary]
	5	HCOIS (PHP&S and West Hollywood Clinic)
	6	PHP&S (Compucare)
	7	AIDS Program Office (APO)
	9	Non-County Physicians (CPO) [Non-Discretionary]
	10	Non-County Hospitals (EMS – CRSIS) [Non-Discretionary)
	11	Non-County Hospitals (EMS – LANCET) [Non-Discretionary)
	12	PHP&S (Health Centers/Utilization Data)
REFERRAL CODE	Attach to separate REFERRAL CODE file.	

TABLE NAME	CODE	
SERVICE EVENTS	0	UNKNOWN
	1	ADMISSION
	2	DISCHARGE
	3	TRANSFER IN
	4	TRANFER OUT
	5	DEATH
	6	BIRTH
	7	RELEASE
	8	VISIT
SERVICE SETTINGS	0	UNKNOWN
	1	HOSPITAL INPATIENT
	2	HOSPITAL EMERGENCY ROOM
	3	HOSPITAL OUTPATIENT
	4	COMPREHENSIVE HEALTH CENTER
	5	HEALTH CENTER
	6	FREE STANDING CLINIC
	7	PHYSICIAN OFFICE
	8	INPATIENT MENTAL HEALTH
	9	INPATIENT REHABILITATION
	10	SKILLED NURSING FACILITY
	11	INTERMEDIATE CARE FACILITY
	12	AMBULANCE
	13	HOME HEALTH CARE
	14	DENTAL
	15	RESIDENTIAL
SERVICE UNITS	0	NOT APPLICABLE
	1	DAY
	2	VISIT
	3	TEST
	4	IMAGE
	5	PRESCRIPTION
	6	SESSION
	7	EPISODE
	8	HOUR
	9	CASE EVALUATION
	10	DURABLE MEDICAL SUPPLES

TABLE NAME	CODE	
SEX	0	UNKNOWN
	1	MALE
	2	FEMALE
SOURCE OF INCOME	0	UNKNOWN
	1	SELF EMPLOYED
	2	DISABILITY
	3	RETIREMENT
	4	PUBLIC ASSISTANCE
	5	OTHER e.g. V. A. benefits, interest, dividends, rent, child support, attorney, etc.
	6	Wages
	9	NONE
SOURCE OF PAYMENT	0	UNKNOWN
	1	SELF-PAY
	2	PRIVATE INSURANCE
	3	MEDICARE
	4	MEDI-CAL
	5	CHIP/RHS
	6	MISP
	7	OTHER SECTION 17000
	8	OTHER/DONATION
STATUS-CODE	1	PRIMARY (Principal)
	2	OTHER
TYPE OF EMPLOYMENT	0	UNKNOWN
	1	FARMING, FORESTRY, FISHING
	2	PRODUCTION, INSPECTION, REPAIR, CRAFT, HANDLERS, HELPERS, LABORERS, TRANSPORTATION
	3	SERVICES, SALES
	4	EXECUTIVE, ADMINISTRATIVE, MANAGERIAL, PROFESSIONAL, TECHNICAL AND RELATED SUPPORT
	5	OTHER
	6	UNEMPLOYED

ATTACHMENT B-6

MICRS FIELD DESCRIPTION

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Amount Paid (Expenditures)	The total dollars expended for defined units of service rendered to county patients. (OP visits, IP days, ancillaries)
Carrier Code	A billing code assigned by different facilities. (Three occurrences: Primary carrier code, and two others: Secondary carrier code & tertiary carrier code)
Carrier Paid Amount	The amount paid by a payer for medical services. (Three occurrences: Primary payer paid amount, and two others: Secondary payer paid amount & tertiary payer paid amount)
Census Tract	A statistical subdivision of a Standard of Metropolitan Area with an average population of 4,000.
Clinic Code	The code which specifies hospital outpatient clinic or comprehensive health clinic or community (free-standing) clinic providing services (applicable to sub-projects).
Date of Birth	The month, day, century and year of a person's birth. Used to calculate age at the time of an event. [MMDDCCYY]
Emergency Room Disposition	The code indicating the disposition of patient from an emergency room setting.
Emergency Room Flag	A flag indicating that an immediate action or remedy is required. This distinguishes emergency and non-emergency.
Encounter Date	The month, day, century and year of an outpatient encounter.

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Ethnicity	The code used to designate race or ethnicity.
Family Size	Based on AFP family size definition (Please see attached memo).
HIV DATE	The month, day, century, and year of HIV positive diagnosis.
HIV FLAG	A flag indicating the HIV status of the patient. (0= Non-HIV positive or undetermined, 1= HIV positive)
MICRS Flag	In Patient file a flag that is set if at least one visit is considered indigent in reporting period. In Patient Utilization file a flag indicates the patient is indigent for that visit.
Medi-Cal Identification #	The Medi-Cal identifier issued by the State of California to the patient receiving medical services.
Monthly Income	The total monthly income received for the previous month by all related family members residing with patients. (For more detailed information, please check RFA on page A-6)
Mother Maiden Name	The surname or family name of the mother of the patient.
Other Diagnosis	A diagnosis which may have developed subsequently and have affected the treatment rendered or the length of stay. (Two occurrences: Other diagnosis A, other diagnosis B)
Other Procedures and Services	Other procedures may include any extraordinary interventions, particularly invasive diagnostics during a period of hospitalization. (Two occurrences: Other procedure A, other procedure

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
PT#	Permanent file # assigned by each facility to a patient record.
Patient Birth City Name	The name of the city, town or village where the patient was born.
Patient Birth Country Name	The name of the country where the patient was born.
Patient Birth State Name	The name of the political subdivision of the country where the patient was born (state, province, district, etc.).
Patient First Name	The full first or given name of the patient, minimally the first name initial.
Patient Last Name	The full surname or family name of the patient.
Patient Middle Name	The full middle name of the patient when it is available. Minimally, the middle name initial.
Patient Unique ID	The patient identifier is a unique identifier that distinguishes a patient and the records concerning that patient's medical care from all other patients, across all facilities.
Payer Contact Name	The name of contact person of payer of medical service charges.
Payer ID	A unique identifier for a payer.
Payer Name	The name of a payer of medical service charges.
Payer Phone#	The phone number of a payer of medical service charges.

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Payer Summary ID	A unique identifier for aggregating totals for a payer of medical service charges having a multiple payer identifier.
Payer Mail address	The mail address of a payer of medical service charges.
Principle Discharge Diagnosis	The condition which has been established to have been the chief cause of admission for care.
Principle Procedure Code	The procedure which was performed for definitive treatment rather than diagnostic or exploratory purposes, unless these were the only types of procedures rendered during the event.
Provider Contact Name	The name of the contact person of a provider of medical service.
Provider Identifier #	A unique identifier for a provider (hospital OSHPD number).
Provider Mail Address	The mail address for a provider of medical service.
Provider Name	The name of a provider of a medical service.
Provider Phone #	The phone # for a provider of medical service.
Provider Site Address	The site address for a provider of medical service.
Provider Site Id	Provider site identification number for CPO.
Provider Summary ID	A unique identifier for a provider of medical service having multiple provider identifiers.

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Provider Zip Code/	The provider's zip code used for indicating location.
Provider-Relation to LACO	The code used to designate the category of organizational or contract relationship to the County indigent care program.
ROV Place Code	A two digit code used by Registrar Recorder to designate a city or unincorporated area of the County.
Record Source	The code used to designate the source code for each feeder system (Sub-Project).
Referral Source	Source of referral for incident of care. Examples: CHDP, HHRCHC, private physician. Field should be coded with same code as the PAARS data element and Stat Master outpatient visit activity record.
Residence City Name	The name of the city or town where the individual resides.
Residence State Name	The name of the state where the individual resides.
Residence Street Name	Street name, including street direction and apt. designation, of usual or permanent address.
Residence Street No.	Residence Street No. of usual or permanent address.
Residence Zip Code	Zip code of patient's usual permanent address. (99997=NA 99998=Unknown, 99999=Missing
Service Event	The code used to designate a service event category durin an episode of care (admissio discharge, visit, etc.).

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Service Event Charge Amount	The amount charged to a patient for medical services delivered during a service event.
Service Event Date	The date of occurrence of a service event during an episode of acute care. [MMDDCCYY]
Service Setting Code	The code used to designate a provider service setting.
Service Unit Code	The code used to designate the type of unit of medical service.
Service Unit Quantity	The number of units of service provided during an incident of medical service.
Sex	The code used to designate gender. (2=Female, 1=Male, 0=Unknown)
Social Security No.	The patient's social security number.
Source of Income	The code used to designate the primary or largest single source of family income.
Source of Payment	The code indicating the source of payment for all or a portion of the patient's bill. One for each amount paid.
TPS#	Trauma Patient Summary Number. This field is an eight (8) digit alphanumeric code assigned to trauma patients treated at designated trauma hospitals.
Type of Employment	The code used to designate the occupation of the patient's family's primary wage earner.
Type of Outpatient Service	The code used to designate different outpatient service category by the care rendered or the specialty of the provider (e.g., clinic code, medical service, etc.)

ATTACHMENT B-7

MICRS PROVIDER PROFILE

ATTACHMENT B-8

MICRS DATA MAPPING

ATTACHMENT B-9

PPP PROGRAM CLAIMS PROCESSING SERVICES

SAMPLE REPORTS

A. REFUND REPORT

Purpose: Refund Tracking

Data Elements	Format*	Frequency*
Patient Name DOS Physician Tax ID # Amount of Original Payment Amount of Refund Difference Reason Method (payment/credit)	Hardcopy	Monthly

B. MOST FREQUENT PROCEDURES

Purpose: Management

Data Elements	Format*	Frequency*
Most Frequent Procedures billed (Top 50) with with reimbursement rates.	Electronic	Monthly

* The COUNTY may at, its discretion, request CONTRACTOR to provide reports in specified electronic data format media and on specified computer media, and specified frequency (e. g., Weekly, Bimonthly, Quarterly, Semi-Quarterly, Biannually, Annually, etc.).

C. MOST FREQUENT ICD-9 CODES

Purpose: Management

Data Elements	Format*	Frequency*
Top 20 billed ICD-9 codes, by clinic site.	Electronic	Monthly

D. UNDUPLICATED PATIENT COUNT

Purpose: Management and Evaluation

Data Elements	Format*	Frequency*
Number of unduplicated patient count, by clinic site.	Hardcopy	Monthly

E. RANDOM SAMPLE OF UNDUPILCATED PATIENTS

Purpose: Management and Evaluation

Data Elements	Format*	Frequency*
Name of unduplicated patients with all associated primary care visits listing CPT & ICD 9 codes and description for each patient visit, by clinic site.	Hardcopy	Monthly

EXHIBIT C

SERVICES FOR THE METROCARE PHYSICIAN PROGRAM (MPP) CLAIMS ADJUDICATION SERVICES STATEMENT OF WORK

1. Definitions:

A. Claims Adjudication Services: Claims adjudication services for the MPP include receipt, review, Medi-Cal coverage identification, MPP eligibility determination, provision of preliminary payment listings and final payment information in electronic formats for MPP claims submitted by physicians for eligible medical services rendered to eligible indigent patients transferred to or treated at a contracted non-County hospital. These services shall be provided according to MPP policies, procedures, and instructions, which are subject to revision from time to time. For purposes of this Agreement, a claim includes a Centers for Medicare and Medicaid Services ("CMS-1500") Form, formerly known as a Health Care Financing Administration ("HCFA") 1500 Form, Attachment C-1, and will include a Medical Alert Center (MAC) transfer authorization number, (Box 11 of CMS-1500 Form), or as otherwise identified as a "MetroCare" claim. Other forms may be approved and required by the Director.

G. Program Year ("PY"): As used herein, the term "program year" shall mean the twelve (12) month period beginning December 1st of a year and ending November 30th of the following year.

H. Hard-Copy Claim: As used herein, the term "hard-copy claim" shall mean a claim that is submitted to Contractor on paper (hard-copy Form CMS-1500) by MetroCare physicians for reimbursement of eligible medical services rendered to eligible indigent patients.

I. On-line Access: As used herein, the term "on-line access" shall mean the electronic linkage of Contractor's computerized claims adjudication system to County personal computers (PCs) located at County specified sites (minimum of two (2)) which permit County access to the MetroCare Physician Profile Database ("PPD") and MPP Database.

J. Administrative Appeal: As used herein, the term "Administrative Appeal" shall mean an appeal which 1) involves an issue exclusively related to the MPP policies and procedures; and 2) does not involve medical issues.

K. Medical Appeal: As used herein, the term "Medical Appeal" shall mean an appeal which involves a

departments. The word "County" or "Director" shall be deemed to refer to the CPM.

4. Services to Be Provided: Services to be provided immediately upon Board of Supervisors approval include, but shall not be limited to:

A. Contractor shall process hard-copy and electronic claims using an on-line claims processing system and line-item and/or on-line adjudication.

B. Contractor's claims review and processing procedures must include, but shall not be limited to, the following:

1) Sorting claims.

2) Date-stamping (i.e., Month/Date/Year) all claims upon receipt, at the time of the original submission and any subsequent resubmission(s).

3) Reviewing claims for completeness and accuracy based on the MPP billing instructions provided by County.

4) Rejecting and returning claims which are incomplete or inaccurate and return to the submitting physician within five (5) working days of claim receipt, with a Director approved letter stating the claim deficiencies and the procedures for

resubmission, or as otherwise agreed to by Director and Contractor.

5) Entering the contract hospital code.

6) Entering the service setting as emergency, inpatient, and limited outpatient [one (1) follow-up visit] medical services through acute hospitalization and one (1) outpatient visit authorized by the County, reason for rejection, claim receipt date, physician's name and tax identification number ("ID#"), patient's name, date of service, and service location on Contractor's system.

7) Entering all claim information and all data elements (Attachments C-2 to C-5) into its system for all complete claims.

8) Flagging all incomplete, erroneous, and duplicate claims.

9) Reflecting line-item denials.

10) Validating procedure and diagnosis codes.

11) Matching Medi-Cal Eligibility History File and Matching Data Elements: Comparing the patient information data provided by County to Contractor against Medi-Cal eligibility history files within ten

(10) working days of receipt to identify claims with Medi-Cal coverage.

Contractor shall be responsible to match the following specified Physician claim data elements, if present, against the Medi-Cal eligibility history file:

- Name
- Date of Birth
- Gender
- Social Security Number (SSN), if present
- Date of Service
- Insertion of Medi-Cal Unit Number: Determine unit number, utilizing the eligibility trailer, to be inserted in the fourth position of the Medi-Cal number.

Contractor recognizes that the County format may change from time to time as a result of changing requirements or needs. At County's option, Contractor shall include or delete County specified matching data elements. A successful match shall meet all of the above data elements.

Contractor shall provide an electronic data listing of Medi-Cal eligible patient information if

requested by the Director. The electronic data transmitted shall include the following information:

- Contractor Log Number
- Patient's:
  - ID/SSN
  - Medi-Cal Number
  - MAC Transfer Authorization Number
  - Last Name
  - First Name
  - Middle Initial
  - Address:
    - Street Address
    - City
    - State
    - Zip
  - Gender
  - Date of Birth
  - First Date of Service
  - Filler or Reserve
  - Contract Hospital Code
  - Any other information requested by Director.

12) Denying Medi-Cal covered claims.

13) Adjudicating claims which are not Medi-Cal covered within ten (10) working days of determination that the claim is non Medi-Cal, for a total of twenty (20) working days from the date of receipt.

14) Automatically/manually assigning a unique claim number.

15) Performing audits and quality assurance sampling.

16) Providing claims reporting.

17) Performing other claim edits, as may be required by Director, from time to time.

18) Accepting amounts from the Director to be paid for each claim type, fund, and organization code, and being able to suspend any unprocessed claims which are not to be paid in the current payment cycle, and include any suspended claims in the next payment cycle in the order of the date received .

19) Preparing Remittance Advices ("RA"), pursuant to Attachment C-6 "Sample Remittance Advice Specifications", for claims adjudicated for payment and those denied due to Medi-Cal coverage, including the applicable Medi-Cal numbers, and electronically transmitting via email the RAs on a bi-weekly basis to County site.

20) Slowing or ceasing claims adjudication services, upon Director's request, in order not to exceed MPP funding limits.

21) Providing an electronic warrant file to County's Auditor Controller, which will group the claims by funds, including an electronic copy of the warrant register

22) Processing an updated copy of the electronic warrant file, including the issue date and warrant number provided by the County, on the same day if received by no later than 10:00 a.m., and by the next business day if not, using high speed, secure electronic media, as specified and agreed to by Director, to transmit and receive the electronic warrant files and add them to the RA before it is printed.

23) Providing mailing services, i.e, addressing, stuffing, sealing, and mailing RAs, including the RAs for denied claims, to MetroCare physicians (County will reimburse Contractor $0.015 per claim and the postage costs associated with the mailing). On the same day of mailings Contractor shall electronically transmit, via email, the RA report to DHS Fiscal Services.

24) Making all applicable MetroCare Fee Schedule modifications, per hospital contract, to its claims adjudication programs necessary to process and adjudicate all MPP claims and comply with this exhibit, the attachments, and modifications thereto, at no additional cost to County.

25) Recouping funds or reducing a physician's future claim payments (e.g., if the claim has been erroneously paid or if the physician receives a payment from the patient or third-party payor, after the claim has been paid), as instructed by Director, via a Director approved letter with recoupment payments to be sent directly to County along with a copy of the RA to County, or if the RA is not available, advising physicians to provide the following information along with the refund check:

- patient's name,
- Contract Hospital Code
- MAC Transfer Authorization Number
- patient's social security number,
- date of service,
- amount of patient's refund,
- physician's tax ID number, and
- physician's license number;
- adjusting the physician account balances accordingly when a refund is received and,
- at Director's discretion, providing the Director or his designee(s) with access to Contractor's system to either cancel claim

in full or indicate partial refund adjustment.

C. Establish and maintain a unique PPD and MPP Database that can provide information related to a FY, CY or PY.

1) The PPD shall incorporate all data elements described in Attachment C-8, Contract Physician Profile Record Layout. Contractor shall regularly update the PPD to ensure that physician information, as requested on the Physician Enrollment Form, is readily available to Director. The PPD shall be based on Attachment C-3, Physician Enrollment Form and Attachment C-2, Conditions of Participation Agreement, which each participating physician submits upon entry into MPP and updates each CY or more often as necessary. The Physician Enrollment Form shall serve as written notice from the physician that information may be entered into the Database.

2) The MPP Database incorporates all data elements necessary for all MPP related work, including, but not limited to, preparing reports, providing Medically Indigent Care Reporting System

("MICRS") data, and as otherwise described within this Agreement and related Attachments.

D. Provide MICRS data according to County specifications, as specified in Attachments:

- C-8: MICRS Statement of Work
- C-9: Record Layout/MICRS Dictionary
- C-10: MICRS Code Tables

E. Review, analyze, and research all Administrative Appeal issues and recommend County action based on MPP policies and procedures. Contractor shall regularly attend scheduled meetings of the County's Physician Reimbursement Advisory Committee ("PRAC"). Upon Director's approval, Contractor shall refer all Medical Appeals to the Physician Appeals Board. Contractor shall prepare appeal summaries and notifications to physicians of appeal disposition. Responses to claim appeals shall be issued by Contractor with a Director approved letter, stating the appeal disposition and an updated RA, if appropriate. All claim appeal response letters are to be approved by Director and mailed by Contractor.

F. Provide system connectivity to two (2) County specified work stations to be designated by County's Project Manager. Contractor shall also provide the

capability for County's personal computers, linked to Contractor's system, to have inquiry capability and to request manipulation of any and all data elements in the MPP Database and PPD and download as an ASCII, comma delimited, or Microsoft Excel file, at the Director's election, the results and/or summary of such manipulation onto County's personal computers. If requested by Director, Contractor shall provide three (3) days of formal training for County on-line users and assistance as necessary for each year during the term of the Agreement. Director shall select the two (2) persons for which training will be provided.

In the event that special hardware is necessary in order to access the Contractor's system or to link County's two (2) work stations to Contractor's system, Contractor shall provide such hardware (including software) for County's use. Contractor shall install and maintain all hardware (including software) provided to County herein.

G. Develop, maintain, and provide detailed written instructions for physician submission of claims, including electronic, as approved by Director. As needed or requested by Director, Contractor shall have workshops for

County staff, physicians, and physician billing groups to support claim submission, both electronic and manual.

H. Provide and manage a telephone hot line for physicians to inquire on the status of claims. Questions regarding the MetroCare program or policy issues are to be referred to Director. Upon physician request, Contractor will send out the Director's approved billing instructions. The hot line must be staffed from 8:00 a.m. to 4:30 p.m., Pacific Standard Time, Monday through Friday, except County holidays. At a minimum, the hot line must have voice mail or other message capabilities to receive calls during non-operation hours. Except for holidays and weekends, calls must be returned within 24 hours. A log of all calls must be maintained and shall include, but shall not be limited to:

- physician's name,
- billing group name,
- caller's name,
- claim number,
- date and time of call,
- a brief summary of the purpose and disposition of the call, and
- name of person who took the call.

This log shall be made available to Director upon request at all reasonable times, for review and for photocopying.

I. Prepare written materials for review and approval by Director prior to distribution (addressing, stuffing, and sealing envelopes) to physicians and deliver same to Director.

J. Develop and maintain a Backup System consisting of an electronic copy of the MPP Database, PPD, and all other related data on CD or on other County specified computer media off-site. The MPP Database shall be backed up on a daily basis; the PPD shall be backed up regularly. In the event that Contractor's system becomes inoperative, Director and Contractor shall mutually agree on a reasonable time frame to resume processing physician claims.

K. Provide Online Access to all active PY physician claims until year-end reconciliation has been completed and determined closed by County.

5. Additional Requirements: In performing the services hereinabove, Contractor shall:

A. Perform at all times in a professional and businesslike manner when assisting physicians and answering physician's questions.

B. Employ industry standards to ensure appropriate payments to physicians under the MetroCare program.

C. Respect the confidential nature of all information with regard to physician patient records and MPP financial records. Contractor acknowledges the confidentiality of all physician patient data and, therefore, shall obtain/extract only that information needed to meet claims processing and adjudication requirements. All such collected information shall become the property of County upon the termination of this Agreement, unless otherwise agreed to by Director.

D. Prepare all correspondence to physicians in a professional and businesslike manner; no correspondence may be hand written and all correspondence to physicians must be approved by Director in writing prior to sending, unless otherwise directed by County's Project Manager.

6. Optional Services: The County may exercise its option to require the Contractor to perform specific optional services. County may require the Contractor to provide Medicare eligibility matching and/or the services of an Audit Nurse

Specialist, who will work with County staff to ensure the medical codes listed on the claims are appropriate, no more than two 8-hour days per month. The nurse will be required to have knowledge of medical and financial coding.

7. Access to information: In order for Contractor to provide the services described in this Exhibit, Director shall provide Contractor necessary and pertinent MPP information, including operational/administrative records, and statistics.

Contractor shall return all the material provided by Director, upon his/her request, including but not limited to, MPP Database data files, PPD data files, physician patient records/data, MPP financial records, all information incidental to contract administration, all completed work, all MPP and MICRS data, in the same condition and sequence in which received within thirty (30) calendar days from date of request.

8. Reports: Contractor shall provide financial, management, and ad-hoc reports, as requested by CPM. Contractor shall submit a weekly report listing all claims received in-house, and claims denied, rejected, Medi-Cal covered, and adjudicated by either CY, PY, or FY of service as requested by CPM. Claim management reports shall be submitted to CPM and shall include, but not be limited to, the following:

- Monthly reports with amounts of various payment categories and a monthly report that reflects weekly claim activity;
- Claims submitted and paid by individual physicians;
- Summary Reports (type/payment/status of claim);
- Claims by month or services or payment;
- Claims by contract hospital name
- Claims by physician tax ID#;
- Claims by physician license number;
- Claims reporting by procedure, diagnosis, and physician specialty by tax ID# and license number;
- Statistics and special reporting;
- RA Reports; and
- Ad-hoc reports, such as top 100 surgical codes, top 100 procedure codes, reports by physician specialty, and reports by hospital code to be provided within five (5) working days of written request.

The monthly report shall include weekly claim activity and shall reflect the number of rejected, denied, denied due to Medi-Cal coverage, and adjudicated claims, as well as number of claims received in-house but which have not been processed and/or adjudicated. As each month of claims processing services

is completed, the monthly report describing that month's claim activity is to be submitted to CPM within ten (10) working days of the end of that completed month. Contractor shall provide analysis and interpretation of reports, as needed.

Contractor shall prepare all the necessary reconciliation reports (monthly, quarterly, biannually, yearly, or as otherwise requested by CPM) for each FY, CY or PY, as requested by CPM, and make any and all necessary payment and/or refund adjustments. Contractor shall re-adjudicate MPP claims (due to changes in reimbursement rates by a percentage to be determined), as may be deemed necessary by CPM, and County shall pay for re-adjudicating the claims.

If at any time re-adjudication is necessary due to an error of the Contractor, then no additional per-claim cost shall be due to Contractor.

Director and Contractor shall mutually work to ensure that County's records and Contractor's MPP database are fully reconciled. Each PY shall be fully and completely reconciled as determined by Director.

9. Records and Audits: Subject to the conditions and terms set forth in the body of Agreement, Contractor agrees to make all billing and eligibility records available upon request, during normal business hours, to Director and authorized State

and federal representatives, for inspection, audit, and copying. Contractor may use microfilm or other media for purposes of maintaining hard copy claim files. Contractor shall provide to Director such material in County specified electronic data format and on specified computer media.

Such records shall be retained in accordance with the RECORDS AND AUDITS Paragraph of the ADDITIONAL PROVISIONS.

10. Quality Improvement: Contractor shall provide to Director a written description of the quality control and claim management procedures employed by Contractor to process and adjudicate MPP claims.

Quality control and claim management procedures shall include, but are not limited to, appropriate claim edits to ensure payment accuracy, non-payment of out-of-County claims, flagging of duplicate billings and overpayments which require Contractor to recoup funds or to reduce a physician's future claim payments, and audit trails to substantiate all adjudicated claim payment authorizations.

Director may periodically sample Contractor's work and request Contractor to provide an audit of its internal claims processing/adjudication procedures in order to determine the accuracy of Contractor's claims processing/adjudication practices. Should any work be inaccurate, as determined by

Director, Director will notify Contractor within a reasonable period of time of such findings. Contractor shall correct any and all inaccuracies within ten (10) working days of receipt of notice of any errors and such correction shall be at no additional cost to County. In the event that Director finds that the errors have not been corrected by Contractor, the cycle of corrective action by Contractor and re-sampling by Director may, at Director's sole discretion, be repeated. Director will notify Contractor within a reasonable period of time of the re-sampling results.

11. Payment: Contractor shall bill County in arrears. The sole compensation to Contractor for services provided hereunder shall be as follows:

A. Emergency Inpatient and/or limited outpatient [one (1) follow-up visit] medical services through acute hospitalization and one (1) outpatient visit authorized by the County:

1) Set-up Fees: Contractor shall receive a one-time set-up fee.

2) Systems Modifications: Contractor shall receive a fee of $80 per programming hour or prorated portion thereof for periods less than one hour for revised or new programming requested by Director, the

rate and process which the parties will use as described below:

a) Contractor shall submit to Director a quotation in writing for the projected work, including an estimated number of programmer hours for completion of the programming task.

b) Director shall determine the credibility of the estimate submitted by Contractor and, if necessary, revise the estimated number of hours requested for performing the programming task. Director shall apprise Contractor in writing of County's acceptance of the quotation or of the revised estimate within ten (10) calendar days of the Director's receipt of the quotation.

c) Contractor shall, upon completion of the work, submit an invoice to County with the actual number of hours that was required to complete the programming Task, not to exceed, however, the number of hours for completion for the task as approved by Director in accordance with Subparagraph (2) above, and prepare and keep detailed records of staff work and time spent on

any programming task hereunder, and shall make them available for audit and photocopying upon request by County representative pursuant to Paragraph 9 (Records and Audits) of this Exhibit.

3) Adjudication Fees:

a) Contractor shall receive, the following fees for each manual (hard-copy) and electronic service claim adjudicated during a contract year that results in payment to a MetroCare Physician by the County or a denial due to Medi-Cal coverage:

	Manual	Electronic
Year 1	$2.85	$1.50
Year 2	$3.00	$1.60
Year 3	$3.00	$1.60
Year 4	$3.15	$1.65
Year 5	$3.15	$1.65

B. Mailing Services: County will reimburse Contractor $0.015 per claim for the actual cost of postage associated with the mailing described in Paragraph 4, Services To Be Provided, Subparagraph B, 23 of this Exhibit.

C. Medi-Cal Coverage Matching: Contractor shall receive a fee of $1,000 per month to perform Medi-Cal eligibility matching.

D. MAC Number Matching: Contractor shall not receive a fee for MAC matching.

E. Printing Services: Contractor shall receive reimbursement for their costs of printing services (e.g. physician enrollment packages, MPP newsletters, etc.).

F. Optional Services

1) Audit Nurse Specialist: Contractor shall receive a fee of $40 per hour or prorated portion thereof for periods less than one hour for the services provided by an Audit Nurse Specialist, as described in Paragraph 6, Optional Requirements.

2) Medicare Eligibility Matching: Contractor shall receive a fee of $1,500 per month to perform Medicare eligibility matching.

3) MICRS Reporting: Contractor shall not receive a fee for MICRS Reporting, as described in Attachment C-2, Conditions of Participation Agreement.

G Corrections: Corrections of any and all claims due to Contractor's errors, as determined by County, shall be performed at no cost to County. County may periodically

sample the work to determine the accuracy of processing. Should any work be inaccurate, as determined by County, Contractor shall promptly correct all inaccurate or unacceptable work to conform to the requirements of this Exhibit, in accordance with Paragraph 10, Quality Improvement, and the Attachments, or as otherwise determined by County. County may withhold fifteen percent (15%) of Contractor's invoice amount until all claims processing services work is acceptable to County. County will provide written notice to Contractor within a reasonable period of time of any claims processing services work which is not acceptable to County.

H. Specified Time Period: County shall be liable to Contractor with regard to amounts payable to Contractor for services performed hereunder only in so far as the claims for service dates that fall within a contract period specified in the Agreement are received by Contractor.

I. Invoices: Contractor shall submit a monthly invoice, in arrears, showing all claims processed and adjudicated and amount of Medi-Cal eligible claims and the costs for mailing services for the previous month of service. County shall pay all invoices within thirty (30) calendar days from receipt of complete and correct billing,

as determined by Director. County shall only reimburse Contractor for each adjudicated claim that result in payment to MetroCare Physician by Director or Denied Medi-Cal eligible claim.

If at any time re-adjudication is necessary due to an error of the Contractor, then no additional per-claim cost shall be due to Contractor.

J. Accuracy of Work: Corrections of any and all claims due to Contractor's errors, as determined by Director, shall be performed at no cost to County. County may periodically sample the work to determine the accuracy of processing. County will provide written notice to Contractor within a reasonable period of time of any claims processing services work which is not acceptable to County. Contractor shall promptly correct all inaccurate or unacceptable work to conform to the requirements of this Exhibit and Attachments at no additional cost to County. County may withhold fifteen percent (15%) of Contractor's invoice amount until all claims processing services work is acceptable to County.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM – METROCARE

DECEMBER 1, 2006 – NOVEMBER 30, 2007
CONDITIONS OF PARTICIPATION AGREEMENT

SUBMIT TO: AMERICAN INSURANCE ADMINISTRATORS (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340

The undersigned physician (hereinafter "Physician") certifies that claims submitted hereunder are for emergency, inpatient, and/or limited outpatient (one [1] followup visit) services provided by him/her to patients who do not have health insurance coverage for such care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole by the federal government.

Physician acknowledges receipt of a copy of the "Physician Services for Indigents Program – Metrocare (PSIP-M) Billing Procedures" (hereinafter "Billing Procedures"), promulgated by the County of Los Angeles, Department of Health Services, for December 1, 2006 through November 30, 2007.

Physician certifies that claims for emergency, inpatient, and/or limited outpatient (one [1] followup visit) services shall only be submitted for patients transferred to or treated at a contracted non-County hospital for indigent services and have a Medical Alert Center transfer authorization number which shall be provided as part of the HCFA-1500.

Physician agrees that all obligations and conditions stated in the Billing Procedures will be observed by him/her, including, but not limited to, the proper refunding of monies to the County when patient or third-party payments are made after reimbursement under this claiming process has been received; the cessation of current, and waiver of future, collection efforts from the patient upon receipt of payment by County; and the preparation, maintenance, and retention of service and finance records, including their availability for audit. Physician affirms that for all claims submitted, reasonable efforts to identify third-party payers have been made, no third-party payers have been discovered, and no payment has been received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor for reimbursement as a result of care and services provided by Physician, and/or his/her staff, upon payment by County under the PSIP-M. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law regardless of the amount the Physician has received under the PSIP-M (e.g., physician's full billed charges). Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

Physician expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to conditions defined in the Billing Requirements, including, but not limited to, (1) availability of monies in the PSIP-M, (2) priority of claim receipt, and (3) audit and adjustments. In accordance with instructions in the Billing Procedures, Physician agrees to submit required documents for claims, and provide other patient data as may be required by the County.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

TYPED/PRINTED NAME OF PHYSICIAN	TAX ID NUMBER
PRIMARY SPECIALTY OF PHYSICIAN	SIGNATURE OF PHYSICIAN
STATE LICENSE NUMBER	DATE

ATTACHMENT C-3

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAM

PROGRAM ENROLLMENT PROVIDER FORM FISCAL YEAR 2006/07

Completion of Enrollment Form is required annually by each physician

Physician Name: _____
(Last Name) (First Name) (M.I.)

Address: _____ City: _____ Zip Code: _____

Telephone No.: (____)_____ Contact Person: _____

E-mail Address: _____

Primary Specialty: _____ State License Number: _____

U.P.I.N.: _____ Payee Tax I.D.#: _____

Payee Address: _____ City: _____ State: _____ Zip Code _____

Physician/Group name must match IRS Tax ID Number

IF PAYEE IS A PHYSICIAN GROUP, COMPLETE GROUP INFORMATION BELOW:

Group Name: _____

IF USING A BILLING COMPANY, COMPLETE BILLING COMPANY INFORMATION BELOW:

Company Name: _____ E Mail Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: ( ) _____ Contact Person: _____

LIST ALL HOSPITALS WHERE MEDICAL SERVICES ARE PROVIDED WITHIN LOS ANGELES COUNTY

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

If information on this form changes in any way, a new provider application must be submitted with the corrected information. This application must be completed by each physician providing services claimed under this program.

As a condition of claiming reimbursement under the Physician Services for Indigents program and/or the Trauma Physician Services Program, I certify that the above information is true, and complete to the best of my knowledge.

_____ _____
SIGNATURE OF PHYSICIAN DATE

IMPORTANT: For prompt processing, return this form as soon as possible to:

AMERICAN INSURANCE ADMINISTRATORS
P.O. BOX 2340
Bassett, CA 91746-0340

COUNTY OF LOS ANGELES ¥ DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM – **METROCARE**

PHYSICIAN REIMBURSEMENT POLICIES

December 1, 2006 through November 30, 2007

I. POLICY STATEMENT

THE PURPOSE OF THIS POLICY IS TO ENSURE THE COUNTY'S CONFORMANCE WITH STATUTORY AND REGULATORY REQUIREMENTS, AND TO ADDRESS PRIORITIES OF THE HEALTH CARE SYSTEM WHICH ARE CRITICAL TO PROVIDING FOR THE MEDICAL NEEDS OF THE INDIGENT POPULATION IN THE COUNTY'S METROCARE PROGRAM.

II. GENERAL RULES

A. Metrocare Fee Schedule: The County utilizes the most current Physicians' Current Procedural Terminology ("CPT-4") codes which coincides with the current Resource Based Relative Values Scale ("RBRVS") unit values and pays at 100% of Medicare reimbursement, not to exceed billed charges. Reimbursement is also limited to the policy parameters contained herein.

B. Eligible Period: Reimbursement shall be for emergency, inpatient, and limited outpatient (one [1] followup visit) medical services through acute hospitalization and one (1) outpatient visit authorized by the County.

C. Exclusions:

1. Procedures which are not covered under Medicare are excluded from reimbursement.

2. Claims determined to be third party eligible, including Full Scope Medi-Cal and Medicare, will be denied. Claims for patients with Limited Scope Medi-Cal will be restricted to services not covered by Medi-Cal.

D. Assistant Surgeons: Reimbursement for assistant surgeons will be at a rate of 20% of the primary surgeon's fee (as per Medicare reimbursement above).

E. Multiple Surgery Procedure Codes: Adjudication of claims involving multiple surgery procedure codes performed in an inpatient operating room requires submission of operative reports. The Procedure Codes shall be paid as follows: 100% for 1st procedure, 50% for the 2nd through the 4th procedures, and the remaining to be paid upon review of the operative reports.

F. Nurse Practitioner and Physician's Assistant Services: Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician's assistants in California.

G. Office Visits: Physicians will be reimbursed for one post-discharge Medicare eligible office visit, if medically necessary as authorized by the County.

III. INELIGIBLE CLAIMS

A. Duplicate Procedures: Claims which include duplicate procedures provided to the same patient for the same episode of care are generally excluded from reimbursement except as otherwise authorized by Medicare. This does not apply for Evaluation & Management codes billed by separate physicians.

B. Unlisted Procedures: Procedures which are not paid by Medicare are excluded from reimbursement.

C. Non-physician Procedures: Procedures commonly not performed by a physician will be denied (e.g., venipuncture).

D. Insurance Rejections: Claims for patients with potential insurance or other third-party payer coverage will be denied unless a notice of rejection from the insurance company or other third-party payer is provided to the County. The rejection notice should indicate either (1) the patient is not a covered beneficiary or (2) the term of coverage expired prior to the date of the claimed service. If insurance or other third-party coverage has been denied for other reasons, e.g., the deductible has not been met, the type or scope of service has been classified as a nonemergency, or other similar issues denying insurance coverage, the claim will be denied. Where limited insurance policies have been exhausted by hospital billings, physician claims will be reviewed and considered on appeal.

IV. EXCLUSIONS

A. Radiology/Nuclear Medicine: Reimbursement for radiology codes will be limited to those appropriate to the differential diagnosis for the patient in the emergency department or inpatient setting.

B. EKGs: Reimbursement for EKG codes will be limited to those appropriate to the differential diagnosis for the patient in the emergency department or inpatient setting.

C. Pathology: Reimbursement for pathology codes will be limited to those codes eligible by Medicare.

D. Anesthesia: There are no exclusions as long as the procedure is billed per American Society of Anesthesiologists (ASA) codes.

V. ADDITIONAL EXCLUSIONS

Upon approval of the Board of Supervisors, the County may revise the Physician Reimbursement Polices from time to time as necessary or appropriate.

VI. APPEALS

Appeals for claims rejected or denied may be submitted to the Physician Reimbursement Advisory Committee ("PRAC"), a committee of physicians selected by Hospital Council of Southern California and by the Los Angeles County Medical Association. Appeals shall include the HCFA-1500, operative reports, if applicable, and supporting documents as needed. Appeals shall be mailed to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: APPEALS UNIT - METROCARE

EMSA:12/18/06

COUNTY OF LOS ANGELES ● DEPARTMENT OF HEALTH SERVICES

PHYSICIAN SERVICES FOR INDIGENTS PROGRAM -- METROCARE

BILLING PROCEDURES

December 1, 2006 – November 30, 2007

I. INTRODUCTION

Pursuant to existing contracts with non-County hospitals for indigent services for MetroCare, a Physician Services for Indigents Program-METROCARE ("PSIP-M") has been established by the County of Los Angeles ("County") to provide reimbursement to private physicians ("Physician") for certain professional services that have been rendered in Los Angeles County to eligible indigent patients. Professional physician services herein referred to are limited to emergency, inpatient, and/or limited outpatient (one [1] followup visit) services.

Professional physician services which can be reimbursed under this claiming process are additionally restricted as prescribed by the County, with such restrictions subject to revision from time to time. Current County physician reimbursement restrictions are set forth in "Department of Health Services Physician Reimbursement Policies for MetroCare, December 1, 2006,- November 30, 2007." attached as Exhibit "A" hereto and incorporated herein by reference. The County has discretion to revise such policies from time to time as deemed necessary or appropriate and if approved by the Board of Supervisors.

In no event may this claiming process be used by Physician if his/her services are included in whole or in part in hospital or physician services claimed by a hospital or by Physician under a separate formal contract with County.

This document defines the procedures which must be followed by Physician in seeking reimbursement under this Program. Submission of a claim by Physician under these procedures establishes (1) a contractual relationship between the County and Physician covering the services provided and (2) signifies Physician's acceptance of all terms and conditions herein.

These claiming procedures are effective December 1, 2006 through November 30, 2007 pursuant to MetroCare agreements with associated hospitals; are only valid for covered services to the extent that monies are available therefor in accordance with maximum amount approved by the Board of Supervisors for the MetroCare Program on November 28, 2006 less payments to participant's contract hospitals, unless further funds are made available upon future approval by the Board; and are subject to revisions as required by State laws and regulations and County requirements. This claiming process may not be used by a physician if he or she is an employee of a County hospital while performing the services.

II. PHYSICIAN ELIGIBILITY

A. Physician must complete a current fiscal year Physician Services for Indigents Program--MetroCare "Conditions of Participation Agreement" and "Program

Enrollment Provider Form" and provide them to the County's contracted Claims Adjudicator (see address on page 4).

B. Physicians who provide emergency, inpatient, and/or limited outpatient (one [1] followup visit) services to eligible patients in a Los Angeles County acute care hospital with a MetroCare Inpatient Program Agreement, may submit claims hereunder, if emergency, inpatient , and/or limited outpatient (one [1] followup visit) services are provided in person, on site, and in an eligible service setting.

C. Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation to the extent the physician is authorized to bill for such services and payment for such services will not be made to any hospital participants in the MetroCare Program where such services were rendered. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.

D. An emergency physician and surgeon or an emergency physician group with a gross billings arrangement with a hospital located in Los Angeles County shall be entitled to receive reimbursement for services provided in that hospital, if all of the following conditions are met:

1. The services are provided in a basic or comprehensive general acute care hospital emergency department.

2. The physician and surgeon is not an employee of the hospital.

3. All provisions of Section III of these Billing Procedures are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

4. Reimbursement is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon or an emergency physician group.

For the purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency

physician and surgeon, or an emergency physician group, and pays a percentage of the emergency physician and surgeon's or group's billings for all patients.

METROCARE

III. PATIENT ELIGIBILITY/BILLING EFFORTS

Patients covered by this claiming process are only those who do not have health insurance coverage for emergency, inpatient, and/or limited outpatient (one [1] followup visit) services, cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole by the federal government, including Full Scope Medi-Cal. Claims for patients with Limited Scope Medi-Cal will be restricted to services not covered by Medi-Cal.

During the time prior to submission of the bill to the County, Physician must have made reasonable efforts to obtain reimbursement and not received payment for any portion of the amount billed. For purposes of this claiming process, reimbursement for unpaid physician billings shall be limited to the following:

(a) patients for whom Physician has conducted reasonable inquiry with the hospital to determine if there is a responsible private or public third-party source of payment (e.g., application for coverage under Medi-Cal and/or Medicare, when appropriate), and

(b) patients for whom Physician has billed all possible payment sources, but has not received full reimbursement.

Upon receipt of payment from the County under this claiming process, Physician must cease any current, and waive any future, collection efforts to obtain reimbursement from the patient.

If, after receiving payment from the County hereunder, Physician is reimbursed by a patient or a responsible third party, Physician shall immediately notify the County (see address below) in writing of the payment, and reimburse the County the amount received from the County.

MAKE REFUND CHECK PAYABLE TO:
County of Los Angeles/Department of Health Services

Refund checks should be accompanied by:
-- a copy of the Remittance Advice, and
-- a specific explanation for the refund, e.g., received payment for services from Medi-Cal, etc.

SUBMIT NOTIFICATION AND/OR REFUND TO:
County of Los Angeles/Department of Health Services
Fiscal Services – MetroCare Program
313 North Figueroa Street, Room 505

Los Angeles, CA 90012

IV. CONDITIONS OF REIMBURSEMENT

Payment is contingent upon adherence to State law and County requirements regarding eligible claims, and provision of data as specified in these Billing Procedures.

V. CLAIM PERIOD

Claims may only be submitted for eligible services provided on/or after December 1, 2006 and through November 30, 2007 pursuant to MetroCare agreement with associated hospitals. All claims for services provided during this period must be received by County's Claim Adjudicator no later than March 31, 2008. Claims received after this fiscal year deadline has passed will not be paid. Unless sooner terminated, canceled, or amended, this claim process shall expire on March 31, 2008.

VI. REIMBURSEMENT

Payment of a valid claim hereunder will be limited to a maximum of 100% of Medicare reimbursement, not to exceed billed charges. The MetroCare Fee Schedule utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Based Relative Value Scale (RBRVS) unit values in affect on the date of admission.

VII. COMPLETION OF FORMS

A. Complete "December 1, 2006 – November 30, 2007 Conditions of Participation Agreement" for the current fiscal year Physician Services for Indigents Program -- METROCARE (sample attached). Submit one original signed Agreement to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340

B. Complete one HFCA-1500 Form per patient including the following:

1. Medical Alert Center (MAC) Authorization number in Section 11, INSURED'S POLICY GROUP OR FECA NUMBER, and
2. The term "METROCARE" in Section 11c, INSURANCE PLAN NAME OR PROGRAM.

3. A copy of the MLK-Harbor Utilization Review Authorization Extension form for any claims beyond the initial six days of inpatient care.

VIII. ELECTRONIC BILLING

As an option, the County's Claims Adjudicator can receive claims electronically. The record layout necessary for electronic submission shall be obtained directly from the County Claims Adjudicator at (800) 303-5242.

IX. SUBMIT CLAIM(S) TO COUNTY'S CONTRACTED CLAIMS ADJUDICATOR

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: METROCARE

X. CLAIM REJECTION AND APPEALS

A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within 20 calendar days from the date of the rejection letter.

B. The Physician must submit an appeal of any denied claim within thirty (30) calendar days from the date of the denied Remittance Advice. A denied claim can be appealed once; however, after the appeal is dispositioned, a further appeal will not be considered. All appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

For Status of Claims, call:
AIA Physician Hotline - (800) 303-5242

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies set forth herein, and allocated therefor by the County of Los Angeles Board of Supervisors. To the extent such monies are available for expenditure under the Physician Services for Indigents Program - MetroCare, and until such available monies are exhausted, valid claims may be paid. Valid claims will be paid in the order of receipt; that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor for reimbursement as a result of care and services provided by Physician, and/or his/her staff, upon payment

by County under the PSIP-M. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law regardless of the amount the Physician has received under the PSIP-M. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

In addition to any Physician duties specified previously herein, Physicians using this claiming process are obligated as follows:

A. Records/Audit Adjustment

1. Physician shall immediately prepare, and thereafter maintain, complete and accurate records sufficient to fully and accurately reflect the services provided, the costs thereof, all collection attempts from the patient and third-party payers, and revenue collected, if any, for which claim has been made under this claiming process.

2. All such records shall be retained by Physician at a location in Los Angeles County for a minimum of three (3) years following the last date of the Physician services to the patient.

3. Such records shall be made available during normal County working hours to representatives of the County and/or State, upon request, at all reasonable times during such three year period for the purposes of inspection, audit, and copying. Photocopying capability must be made available to County representatives during an on-site audit.

4. County may periodically conduct an audit of the Physician's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a single claim, a group of claims, or a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims.

   Audited claims that do not comply with program requirements shall result in a refund to the County. If the audit was conducted on a statistically random

sample of claims, the dollar amount disallowed shall become a percentage of the total paid on the sample, referred to as the exception rate. The audit exception rate found in the sampled claims reflects, from a statistical standpoint, the overall exception rate potentially possible within the universe

METROCARE

of adjudicated claims for that fiscal year. This exception rate may be applied to the total universe of paid claims which will determine the final reimbursement due to the County.

If an audit of Physician or hospital records conducted by County and/or State representatives relating to the services for which claim was made and paid hereunder finds that (1) the records are incomplete or do not support the medical necessity for all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the claimed services, or (3) Physician failed either to report or remit payments received from patients or third parties as required herein, or (4) the patient was ineligible for services hereunder, or (5) Physician did not otherwise qualify for reimbursement hereunder, Physician shall, upon receipt of County billing therefor, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

County also reserves the right to exclude Physician from reimbursement of future claims for any failure to satisfy conditions of this claiming process.

B. Indemnification/Insurance

By utilizing this claiming process, the Physician certifies that the services rendered by him/her, and for which claim is made, are covered under a program of professional liability insurance with a combined single-limit of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate.

By utilizing this claiming process, the Physician further certifies that his/her workers' compensation coverage is in an amount and form to meet all applicable requirements of the California Labor Code, and that it specifically covers all persons providing services on behalf of the Physician and all risks to such persons.

C. Non-discrimination

In utilizing this claiming process, the Physician signifies that he/she has not discriminated in the provision of services for which claim is made because of race, color, religion, national origin, ancestry, sex, age, physical or mental disability, or

medical condition and has complied in this respect with all applicable non-discrimination requirements of Federal and State law.

XIV. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ('HIPAA'). Contractor understands and agrees that, as a provider of medical treatment services, it is a 'covered entity' under HIPAA and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA.

The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH ISINDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY.

EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.

ATTACHMENT C-6

MPP CLAIMS PROCESSING SERVICES

SAMPLE REMITTANCE ADVICE (RA) SPECIFICATIONS

1. CONTRACTOR's Name
2. Fiscal year of service
3. Bill Type (i.e., "trauma", "emergency", "pediatrics". etc.)
4. Warrant Number
5. Warrant Issue Date
6. Heading: County of Los Angeles
   Department of Health Services
   Physician Reimbursement Program
   Remittance Advice – Fiscal Year 2006-07
7. Payee Tax Identification Number
8. Payee's Name and Address
9. Report Date
10. Patient's Social Security Number (Patient ID) / Bill Number
11. Patient's Name (Last name, First name)
12. Patient Account Number
13. Hospital Code
14. Physician License Number
15. Date of service
16. Procedure Code – List all codes involved
17. Amount billed on the claim
18. Adjudicated amount
19. Percentage of adjudicated amount to be paid
20. Amount to be paid
21. Remark Code, if applicable
22. Received date
23. Medi-Cal and Medicare No.
24. Rate %
25. Totals for Paid Claims, by patient:
    a. Amount Billed.
    b. Charges not covered
    c. Adjudicated Amount, and
    d. Amount Paid
26. Totals for Denied Claims, by patient (if applicable):
    a. Amount Billed.
    b. Amount Medi-Cal Denied.
    c. Amount Plan Denied
27. Any other pertinent information

ATTACHMENT C-7

MPP CLAIMS PROCESSING SERVICES

CONTRACT PHYSICIAN PROFILE RECORD LAYOUT

The following is the list of required data elements for the contract physician's profile to be sent to the MICRS staff at the Department of Health Services, Health Services Administration. Data file shall be transmitted via email or made available on-line for downloading, monthly.

#	FIELD NAME	FLD TYPE	FLD LEN	DESCRIPTION (FROM PHYSICIAN APPLICATION FORM)
RECORD B				
1	PRVDR- NAME	A	50	Physician's Name
2	PRVDR STR	A	25	Physician's Office Address
3	PRVDR CITY	A	20	Physician's Office City
4	PRVDR STATE	A	2	Physician's Office State
5	PRVDR ZIP	A	9	Physician's Office Zip Code
6	PRVDR PHON	A	13	Physician's Office Telephone
7	PRVDR CONT	A	50	Physician's Contact Person
8	PRVDR EMAIL	A	20	Physician's Contact Person Email
9	PRVDR SPEC	A	25	Physician's Primary Specialty
10	PRVDR-ID		9	Physician's State License Number
11	PRVDR UPIN	A	15	Physician's U.P.I.N.
12	PRVDR-TID	A	15	Physician's Payee Tax I. D. Number
13	SITE NAME	A	30	Billing Company Name
14	SITE STR	A	25	Billing Company Address
15	SITE CITY	A	20	Billing Company City
16	SITE STATE	A	2	Billing Company State
17	SITE ZIP	A	9	Billing Company zip Code
RECORD A				
1	PAYEE- NAME	A	50	Payee's Name
2	PAYEE STR	A	25	Payee's Office Address
3	PAYEE CITY	A	20	Payee's Office City
4	PAYEE STATE	A	2	Payee's Office State
5	PAYEE ZIP	A	9	Payee's Office Zip Code
6	PAYEE PHON	A	13	Payee's Office Telephone
7	PAYEE CONT	A	50	Payee's Contact Person
8	PAYEE EMAIL	A	20	Payee's Contact Person Email

ATTACHMENT C-8

METROCARE PHYSICIAN PROGRAM (MPP)

MEDICALLY INDIGENT CARE REPORTING SYSTEM (MICRS)

STATEMENT OF WORK

I. GENERAL SCOPE OF WORK

CONTRACTOR shall fully perform, complete and deliver on time all work, deliverables and/or other items, however denoted, as set forth below and in documents attached and referenced herein, in full compliance with the requirements of this Statement of Work.

The general responsibilities of CONTRACTOR under this Agreement shall include, but not be limited to, all labor required to establish data base(s) in order to meet State Department of Health Services ('STATE") and County of Los Angeles ("COUNTY") Physician Services for Indigents Program reporting requirements, produce STATE required data and submit to COUNTY, as described herein and in Attachment A-13 (MICRS Record Lay-Out/MICRS Dictionary) and Attachment A-14 (MICRS Code Tables).

CONTRACTOR will also provide test data for MICRS to ensure that the record layout and format are consistent with program requirements. The test data are due thirty (30) days after adjudication of the first **400** physician claims.

II. BACKGROUND AND OVERVIEW

AB 75 and subsequent legislation implementing the Tobacco Tax and Health Protection Act of 1998 require all counties to report health care costs, utilization and patient demographic data to the STATE. As a result, STATE has mandated COUNTY report the required data by establishing the Medically Indigent Care Reporting System (MICRS) beginning with Fiscal Year 1991-92 and on-going.

This Statement of Work describes the services required of CONTRACTOR to provide data elements from Physician reimbursement claims to the COUNTY in order to meet STATE reporting requirements. The following are procedures for the timely submission of data to COUNTY.

III. PROJECT MANAGEMENT

The County of Los Angeles Department of Health Services' (DHS) Project Manager shall administer the contract and ensure that CONTRACTOR meets or exceeds the contract requirements. The project coordination between CONTRACTOR and COUNTY shall be through the COUNTY's MICRS Project Manager, unless otherwise designated by Director.

IV. DATA REQUIREMENTS AND SUBMISSION PROCEDURES

A. DATA REQUIREMENTS

CONTRACTOR shall prepare MICRS data in the required format, and informational/data requests on an ad-hoc basis. CONTRACTOR shall provide a CD copy, or via a secure electronic data transfer (i.e. ftp – file transfer protocol), of the Contract Physicians Profile file (i.e., Physician Profile Data base (PPD) as described herein and in Attachment A-11 (Contract Physicians Profile Record Layout).

- MICRS Data Requirements

CONTRACTOR will be responsible to collect and maintain current information on Physicians as well as provide the patient utilization information as described in Attachments A-13 (MICRS Record Layout/MICRS Dictionary) and A-14 (MICRS Code Tables).

The MICRS data will be utilized by COUNTY as required by STATE and submitted as annual reports to STATE

CONTRACTOR shall inform COUNTY of any update to the Contract Physicians Profile file (i.e. Physician Profile Data base (PPD) by submitting a copy of the completed Physician Enrollment Form included as Attachment A-5.

B. DATA SUBMISSION PROCEDURES

-MICRS Data Submission Procedures

CONTRACTOR shall prepare and submit, via email, MICRS data to DHS, Health Services Administration, Attention: MICRS Unit.

CONTRACTOR shall format the data according to the record lay-out included in Attachments 13 and 14 (MICRS Record Lay-out/MICRS Dictionary and MICRS Code Tables) and submit the data in a fixed block, ASCII format. CONTRACTOR shall recognize that COUNTY data format requirements may change from time to time as a result of STATE program requirements or COUNTY information requirements, and CONTRACTOR must be able to adjust accordingly.

The data will be submitted on computer media CD, or via a secure electronic data transfer (i.e. ftp – file transfer protocol), which includes the labeling format and mailing address for submitting MICRS data as well as Contract Physician Profile information (i.e. Physician Profile Data base (PPD).

CONTRACTOR is responsible to ensure that the data are correctly identified, appropriately labeled, and loaded on CD or transmitted via a secure electronic data transfer (i.e. ftp – file transfer protocol).

COUNTY shall inspect and review MICRS data provided by CONTRACTOR and reject all improperly formatted or unreadable data within ten (10) work days after receipt thereof CONTRACTOR shall correct such data without additional cost to COUNTY.

ATTACHMENT C-9

MICRS DICTIONARY

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Amount Paid (Expenditures)	The total dollars expended for defined units of service rendered to county patients. (OP visits, IP days, ancillaries)
Carrier Code	A billing code assigned by different facilities. (Three occurrences: Primary carrier code, and two others: Secondary carrier code & tertiary carrier code)
Carrier Paid Amount	The amount paid by a payer for medical services. (Three occurrences: Primary payer paid amount, and two others: Secondary payer paid amount & tertiary payer paid amount)
Census Tract	A statistical subdivision of a Standard of Metropolitan Area with an average population of 4,000.
Clinic Code	The code which specifies hospital outpatient clinic or comprehensive health clinic or community (free-standing) clinic providing services (applicable to sub-projects).
Date of Birth	The month, day, century and year of a person's birth. Used to calculate age at the time of an event. [MMDDCCYY]
Emergency Room Disposition	The code indicating the disposition of patient from an emergency room setting.
Emergency Room Flag	A flag indicating that an immediate action or remedy is required. This distinguishes emergency and non-emergency.
Encounter Date	The month, day, century and year of an outpatient encounter.

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Ethnicity	The code used to designate race or ethnicity.
Family Size	Based on AFP family size definition (Please see attached memo).
HIV DATE	The month, day, century, and year of HIV positive diagnosis.
HIV FLAG	A flag indicating the HIV status of the patient. (0= Non-HIV positive or undetermined, 1= HIV positive)
MICRS Flag	In Patient file a flag that is set if at least one visit is considered indigent in reporting period. In Patient Utilization file a flag indicates the patient is indigent for that visit.
Medi-Cal Identification #	The Medi-Cal identifier issued by the State of California to the patient receiving medical services.
Monthly Income	The total monthly income received for the previous month by all related family members residing with patients. (For more detailed information, please check RFA on page A-6)
Mother Maiden Name	The surname or family name of the mother of the patient.
Other Diagnosis	A diagnosis which may have developed subsequently and have affected the treatment rendered or the length of stay. (Two occurrences: Other diagnosis A, other diagnosis B)
Other Procedures and Services	Other procedures may include any extraordinary interventions, particularly invasive diagnostics during a period of hospitalization. (Two occurrences: Other procedure A, other procedure B)

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
PF#	Permanent file # assigned by each facility to a patient record.
Patient Birth City Name	The name of the city, town or village where the patient was born.
Patient Birth Country Name	The name of the country where the patient was born.
Patient Birth State Name	The name of the political subdivision of the country where the patient was born (state, province, district, etc.).
Patient First Name	The full first or given name of the patient, minimally the first name initial.
Patient Last Name	The full surname or family name of the patient.
Patient Middle Name	The full middle name of the patient when it is available. Minimally, the middle name initial.
Patient Unique ID	The patient identifier is a unique identifier that distinguishes a patient and the records concerning that patient's medical care from all other patients, across all facilities.
Payer Contact Name	The name of contact person of payer of medical service charges.
Payer ID	A unique identifier for a payer.
Payer Name	The name of a payer of medical service charges.
Payer Phone#	The phone number of a payer of medical service charges.

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Payer Summary ID	A unique identifier for aggregating totals for a payer of medical service charges having a multiple payer identifier.
Payer Mail address	The mail address of a payer of medical service charges.
Principle Discharge Diagnosis	The condition which has been established to have been the chief cause of admission for care.
Principle Procedure Code	The procedure which was performed for definitive treatment rather than diagnostic or exploratory purposes, unless these were the only types of procedures rendered during the event.
Provider Contact Name	The name of the contact person of a provider of medical service.
Provider Identifier #	A unique identifier for a provider (hospital OSHPD number).
Provider Mail Address	The mail address for a provider of medical service.
Provider Name	The name of a provider of a medical service.
Provider Phone #	The phone # for a provider of medical service.
Provider Site Address	The site address for a provider of medical service.
Provider Site Id	Provider site identification number for CPO.
Provider Summary ID	A unique identifier for a provider of medical service having multiple provider identifiers.

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Provider Zip Code#	The provider's zip code used for indicating location.
Provider-Relation to LACO	The code used to designate the category of organizational or contract relationship to the County indigent care program.
ROV Place Code	A two digit code used by Registrar Recorder to designate a city or unincorporated area of the County.
Record Source	The code used to designate the source code for each feeder system (Sub-Project).
Referral Source	Source of referral for incident of care. Examples: CHDP, HHRCHC, private physician. Field should be coded with same code as the PAARS data element and Stat Master outpatient visit activity record.
Residence City Name	The name of the city or town where the individual resides.
Residence State Name	The name of the state where the individual resides.
Residence Street Name	Street name, including street direction and apt. designation, of usual or permanent address.
Residence Street No.	Residence Street No. of usual or permanent address.
Residence Zip Code	Zip code of patient's usual or permanent address. (99997=NA, 99998=Unknown, 99999=Missing)
Service Event	The code used to designate a service event category during an episode of care (admission, discharge, visit, etc.).

Medically Indigent Care Reporting System
Data Dictionary

Field Name	Field Description
Service Event Charge Amount	The amount charged to a patient for medical services delivered during a service event.
Service Event Date	The date of occurrence of a service event during an episode of acute care. [MMDDCCYY]
Service Setting Code	The code used to designate a provider service setting.
Service Unit Code	The code used to designate the type of unit of medical service.
Service Unit Quantity	The number of units of service provided during an incident of medical service.
Sex	The code used to designate gender. (2=Female, 1=Male, 0=Unknown)
Social Security No.	The patient's social security number.
Source of Income	The code used to designate the primary or largest single source of family income.
Source of Payment	The code indicating the source of payment for all or a portion of the patient's bill. One for each amount paid.
TPS#	Trauma Patient Summary Number. This field is an eight (8) digit alphanumeric code assigned to trauma patients treated at designated trauma hospitals.
Type of Employment	The code used to designate the occupation of the patient's family's primary wage earner.
Type of Outpatient Service	The code used to designate different outpatient service category by the care rendered or the specialty of the provider (e.g., clinic code, medical service, etc.)

ATTACHMENT C-10

MICRS – CODE TABLE

TABLE NAME	CODE
CITY CODE	Attach to a separate table (LACounty city codes).
CLINIC CODE	Attach to a separate CLNIC code table.
CPT	Attach to separate CPT CODE table (code file has 7.146 records).
ER DISPOSITION	0 NOT APPLICABLE 1 RELEASE 2 TRANSFER TO ANOTHER HOSPITAL 3 ADMISSION 4 DEATH
ER FLAG	0 NOT AN EMERGENCY VISIT 1 ER/NON-EMERGENCY VISIT 2 ER/EMERGENCY VISIT
HIV	0 Non-HIV positive or undetermined 1 HIV positive
ICD	Attach to separate ICD CODE table.
OUTPATIENT SERVICES	0 UNKNOWN 1 PRIMARY CARE 2 SPECIALTY CARE 3 HOME HEALTH CARE 4 DENTAL CARE 5 LABORATORY 6 MEDICAL SUPPLIES 7 OPTOMETRY 8 PHARMACY 9 PODIATRY 10 DETOXIFICATION 11 RADIOLOGY 12 AMBULATORY SURGERY 13 OTHER (RESIDENCY)

TABLE NAME	CODE	
SERVICE EVENTS	0	UNKNOWN
	1	ADMISSION
	2	DISCHARGE
	3	TRANSFER IN
	4	TRANFER OUT
	5	DEATH
	6	BIRTH
	7	RELEASE
	8	VISIT
SERVICE SETTINGS	0	UNKNOWN
	1	HOSPITAL INPATIENT
	2	HOSPITAL EMERGENCY ROOM
	3	HOSPITAL OUTPATIENT
	4	COMPREHENSIVE HEALTH CENTER
	5	HEALTH CENTER
	6	FREE STANDING CLINIC
	7	PHYSICIAN OFFICE
	8	INPATIENT MENTAL HEALTH
	9	INPATIENT REHABILITATION
	10	SKILLED NURSING FACILITY
	11	INTERMEDIATE CARE FACILITY
	12	AMBULANCE
	13	HOME HEALTH CARE
	14	DENTAL
	15	RESIDENTIAL
SERVICE UNITS	0	NOT APPLICABLE
	1	DAY
	2	VISIT
	3	TEST
	4	IMAGE
	5	PRESCRIPTION
	6	SESSION
	7	EPISODE
	8	HOUR
	9	CASE EVALUATION
	10	DURABLE MEDICAL SUPPLES

TABLE NAME	CODE	
SEX	0	UNKNOWN
	1	MALE
	2	FEMALE
SOURCE OF INCOME	0	UNKNOWN
	1	SELF EMPLOYED
	2	DISABILITY
	3	RETIREMENT
	4	PUBLIC ASSISTANCE
	5	OTHER e.g. V. A. benefits, interest, dividends, rent, child support, attorney, etc.
	6	Wages
	9	NONE
SOURCE OF PAYMENT	0	UNKNOWN
	1	SELF-PAY
	2	PRIVATE INSURANCE
	3	MEDICARE
	4	MEDI-CAL
	5	CHIP/RHS
	6	MISP
	7	OTHER SECTION 17000
	8	OTHER/DONATION
STATUS-CODE	1	PRIMARY (Principal)
	2	OTHER
TYPE OF EMPLOYMENT	0	UNKNOWN
	1	FARMING, FORESTRY, FISHING
	2	PRODUCTION, INSPECTION, REPAIR, CRAFT, HANDLERS, HELPERS, LABORERS, TRANSPORTATION
	3	SERVICES, SALES
	4	EXECUTIVE, ADMINISTRATIVE, MANAGERIAL, PROFESSIONAL, TECHNICAL AND RELATED SUPPORT
	5	OTHER
	6	UNEMPLOYED

CONTRACTOR EMPLOYEE ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT

_____
CONTRACTOR NAME

Contract No.: _____

Employee Name: _____

GENERAL INFORMATION:
Your employer referenced above has entered into a contract with the County of Los Angeles to provide certain services to the County. The County requires your signature on this Contractor Employee Acknowledgement and Confidentiality Agreement.

EMPLOYEE ACKNOWLEDGEMENT:
I understand and agree that the Contractor referenced above is my sole employer for purposes of the above-referenced contract. I understand and agree that I must rely exclusively upon my employer for payment of salary and any and all other benefits payable to me or on my behalf by virtue of my performance of work under the above-referenced contract.

I understand and agree that I am not an employee of the County of Los Angeles for any purpose whatsoever and that I do not have and will not acquire any rights or benefits of any kind from the County of Los Angeles by virtue of my performance of work under the above-referenced contract. I understand and agree that I do not have and will not acquire any rights or benefits from the County of Los Angeles pursuant to any agreement between any person or entity and the County of Los Angeles.

I understand and agree that I may be required to undergo a background and security investigation(s). I understand and agree that my continued performance of work under the above-referenced contract is contingent upon my passing, to the satisfaction of the County, any and all such investigations. I understand and agree that my failure to pass, to the satisfaction of the County, any such investigation shall result in my immediate release from performance under this and/or any future contract.

CONFIDENTIALITY AGREEMENT:
I may be involved with work pertaining to services provided by the County of Los Angeles and, if so, I may have access to confidential data and information pertaining to persons and/or entities receiving services from the County. In addition, I may also have access to proprietary information supplied by other vendors doing business with the County of Los Angeles. The County has a legal obligation to protect all such confidential data and information in its possession, especially data and information concerning health, criminal, and welfare recipient records. I understand that if I am involved in County work, the County must ensure that I, too, will protect the confidentiality of such data and information. Consequently, I understand that I must sign this agreement as a condition of my work to be provided by my employer for the County. I have read this agreement and have taken due time to consider it prior to signing.

I hereby agree that I will not divulge to any unauthorized person any data or information obtained while performing work pursuant to the above-referenced contract between my employer and the County of Los Angeles. I agree to forward all requests for the release of any data or information received by me to my immediate supervisor.

I agree to keep confidential all health, criminal, and welfare recipient records and all data and information pertaining to persons and/or entities receiving services from the County, design concepts, algorithms, programs, formats, documentation, Contractor proprietary information and all other original materials produced, created, or provided to or by me under the above-referenced contract. I agree to protect these confidential materials against disclosure to other than my employer or County employees who have a need to know the information. I agree that if proprietary information supplied by other County vendors is provided to me during this employment, I shall keep such information confidential.

I agree to report to my immediate supervisor any and all violations of this agreement by myself and/or by any other person of whom I become aware. I agree to return all confidential materials to my immediate supervisor upon completion of this contract or termination of my employment with my employer, whichever occurs first.

I acknowledge that violation of this agreement may subject me to civil and/or criminal action and that the County of Los Angeles may seek all possible legal redress.

SIGNATURE: _____ DATE: ____/____/____

PRINTED NAME: _____

POSITION: _____

(Note: This certification is to be executed and returned to County with Contractor's executed Contract. Work cannot begin on the Contract until County receives this executed document.)

CONTRACTOR NON-EMPLOYEE ACKNOWLEDGEMENT AND CONFIDENTIALITY AGREEMENT

_____
CONTRACTOR NAME

Contract No.: _____

Employee Name: _____

GENERAL INFORMATION:
Your employer referenced above has entered into a contract with the County of Los Angeles to provide certain services to the County. The County requires your signature on this Contractor Non-Employee Acknowledgement and Confidentiality Agreement.

NON-EMPLOYEE ACKNOWLEDGEMENT:
I understand and agree that the Contractor referenced above is my sole employer for purposes of the above-referenced contract. I understand and agree that I must rely exclusively upon my employer for payment of salary and any and all other benefits payable to me or on my behalf by virtue of my performance of work under the above-referenced contract.

I understand and agree that I am not an employee of the County of Los Angeles for any purpose whatsoever and that I do not have and will not acquire any rights or benefits of any kind from the County of Los Angeles by virtue of my performance of work under the above-referenced contract. I understand and agree that I do not have and will not acquire any rights or benefits from the County of Los Angeles pursuant to any agreement between any person or entity and the County of Los Angeles.

I understand and agree that I may be required to undergo a background and security investigation(s). I understand and agree that my continued performance of work under the above-referenced contract is contingent upon my passing, to the satisfaction of the County, any and all such investigations. I understand and agree that my failure to pass, to the satisfaction of the County, any such investigation shall result in my immediate release from performance under this and/or any future contract.

CONFIDENTIALITY AGREEMENT:
I may be involved with work pertaining to services provided by the County of Los Angeles and, if so, I may have access to confidential data and information pertaining to persons and/or entities receiving services from the County. In addition, I may also have access to proprietary information supplied by other vendors doing business with the County of Los Angeles. The County has a legal obligation to protect all such confidential data and information in its possession, especially data and information concerning health, criminal, and welfare recipient records. I understand that if I am involved in County work, the County must ensure that I, too, will protect the confidentiality of such data and information. Consequently, I understand that I must sign this agreement as a condition of my work to be provided by my employer for the County. I have read this agreement and have taken due time to consider it prior to signing.

I hereby agree that I will not divulge to any unauthorized person any data or information obtained while performing work pursuant to the above-referenced contract between my employer and the County of Los Angeles. I agree to forward all requests for the release of any data or information received by me to my immediate supervisor.

I agree to keep confidential all health, criminal, and welfare recipient records and all data and information pertaining to persons and/or entities receiving services from the County, design concepts, algorithms, programs, formats, documentation, Contractor proprietary information and all other original materials produced, created, or provided to or by me under the above-referenced contract. I agree to protect these confidential materials against disclosure to other than my employer or County employees who have a need to know the information. I agree that if proprietary information supplied by other County vendors is provided to me during this employment, I shall keep such information confidential.

I agree to report to my immediate supervisor any and all violations of this agreement by myself and/or by any other person of whom I become aware. I agree to return all confidential materials to my immediate supervisor upon completion of this contract or termination of my employment with my employer, whichever occurs first.

I acknowledge that violation of this agreement may subject me to civil and/or criminal action and that the County of Los Angeles may seek all possible legal redress.

SIGNATURE: _____ DATE: ____/____/____

PRINTED NAME: _____

POSITION: _____

(Note: This certification is to be executed and returned to County with Contractor's executed Contract. Work cannot begin on the Contract until County receives this executed document.)

EXHIBIT E

CONTRACTOR'S EQUAL EMPLOYMENT OPPORTUNITY (EEO) CERTIFICATION

_____
Contractor's Name

_____
Business Address

_____
Internal Revenue Service Employer Identification Number

GENERAL

In accordance with Section 4.32.010 of the County Code, the Contractor certifies and agrees that all persons employed by such firm, its affiliates, subsidiaries, or holding companies are and will be treated equally by the firm without regard to or because of race, religion, ancestry, national origin, or sex and in compliance with all anti-discrimination laws of the United States of America and the State of California.

CERTIFICATION	YES	NO
1. The Contractor has a written policy statement prohibiting discrimination in all phases of employment.	( )	( )
2. The Contractor periodically conducts a self analysis or utilization of its work force to assure compliance with State and Federal anti-discrimination laws.	( )	( )
3. The Contractor has a system for determining if its employment practices are discriminatory against protected groups.	( )	( )
4. Where problem areas are identified in employment practices, the Contractor has a system for taking reasonable corrective action, to include establishment of goals and timetables.	( )	( )

_____ _____
Signature of Authorized Representative of Proposing Entity — Date

_____ _____
Print Name — Title

EXHIBIT F

COUNTY OF LOS ANGELES CONTRACTOR EMPLOYEE JURY SERVICE PROGRAM CERTIFICATION FORM AND APPLICATION FOR EXCEPTION

The County's solicitation for this Request for Proposals is subject to the County of Los Angeles Contractor Employee Jury Service Program (Program), Los Angeles County Code, Chapter 2.203. All proposers, whether a contractor or subcontractor, must complete this form to either certify compliance or request an exception from the Program requirements. Upon review of the submitted form, the County department will determine, in its sole discretion, whether the proposer is exempted from the Program.

Company Name:		
Company Address:		
City:	State:	Zip Code:
Telephone Number:		
Solicitation For _____ Services):		

If you believe the Jury Service Program does not apply to your business, check the appropriate box in Part I (attach documentation to support your claim); or, complete Part II to certify compliance with the Program. Whether you complete Part I or Part II, please sign and date this form below.

Part I: Jury Service Program is Not Applicable to My Business

- ☐ My business does not meet the definition of "contractor," as defined in the Program, as it has not received an aggregate sum of $50,000 or more in any 12-month period under one or more County contracts or subcontracts (this exception is not available if the contract itself will exceed $50,000). I understand that the exception will be lost and I must comply with the Program if my revenues from the County exceed an aggregate sum of $50,000 in any 12-month period.

- ☐ My business is a small business as defined in the Program. It 1) has ten or fewer employees; and, 2) has annual gross revenues in the preceding twelve months which, if added to the annual amount of this contract, are $500,000 or less; and, 3) is not an affiliate or subsidiary of a business dominant in its field of operation, as defined below. I understand that the exception will be lost and I must comply with the Program if the number of employees in my business and my gross annual revenues exceed the above limits.

  "Dominant in its field of operation" means having more than ten employees, including full-time and part-time employees, and annual gross revenues in the preceding twelve months, which, if added to the annual amount of the contract awarded, exceed $500,000.

  "Affiliate or subsidiary of a business dominant in its field of operation" means a business which is at least 20 percent owned by a business dominant in its field of operation, or by partners, officers, directors, majority stockholders, or their equivalent, of a business dominant in that field of operation.

- ☐ My business is subject to a Collective Bargaining Agreement (attach agreement) that expressly provides that it supersedes all provisions of the Program.

OR

Part II: Certification of Compliance

- ☐ My business has and adheres to a written policy that provides, on an annual basis, no less than five days of regular pay for actual jury service for full-time employees of the business who are also California residents, **or** my company will have and adhere to such a policy prior to award of the contract.

I declare under penalty of perjury under the laws of the State of California that the information stated above is true and correct.

Print Name:	Title:
Signature:	Date:

EXHIBIT G

No shame.
No blame.
No names.

Newborns can be safely given up at any Los Angeles County hospital emergency room or fire station.

In Los Angeles County:
1-877-BABY SAFE
1-877-222-9723
www.babysafela.org

State of California
Gray Davis, Governor

Health and Human Services Agency
Grantland Johnson, Secretary

Department of Social Services
Rita Saenz, Director

Los Angeles County Board of Supervisors
Gloria Molina, Supervisor, First District
Yvonne Brathwaite Burke, Supervisor, Second District
Zev Yaroslavsky, Supervisor, Third District
Don Knabe, Supervisor, Fourth District
Michael D. Antonovich, Supervisor, Fifth District

This initiative is also supported by First 5 LA and INFO LINE of Los Angeles.

What is the Safely Surrendered Baby Law?

California's Safely Surrendered Baby Law allows parents to give up their baby confidentially. As long as the baby has not been abused or neglected, parents may give up their newborn without fear of arrest or prosecution.

How does it work?

A distressed parent who is unable or unwilling to care for a baby can legally, confidentially and safely give up a baby within three days of birth. The baby must be handed to an employee at a Los Angeles County emergency room or fire station. As long as the child shows no signs of abuse or neglect, no name or other information is required. In case the parent changes his or her mind at a later date and wants the baby back, workers will use bracelets to help connect them to each other. One bracelet will be placed on the baby, and a matching bracelet will be given to the parent.

What if a parent wants the baby back?

Parents who change their minds can begin the process of reclaiming their newborns within 14 days. These parents should call the Los Angeles County Department of Children and Family Services at 1-800-540-4000.

Can only a parent bring in the baby?

In most cases, a parent will bring in the baby. The law allows other people to bring in the baby if they have legal custody.

Does the parent have to call before bringing in the baby?

No. A parent can bring in a baby anytime, 24 hours a day, 7 days a week so long as the parent gives the baby to someone who works at the hospital or fire station.

Does a parent have to tell anything to the people taking the baby?

No. However, hospital personnel will ask the parent to fill out a questionnaire designed to gather important medical history information, which is very useful in caring for the child. Although encouraged, filling out the questionnaire is not required.

What happens to the baby?

The baby will be examined and given medical treatment, if needed. Then the baby will be placed in a pre-adoptive home.

What happens to the parent?

Once the parent(s) has safely turned over the baby, they are free to go.

Why is California doing this?

The purpose of the Safely Surrendered Baby Law is to protect babies from being abandoned by their parents and potentially being hurt or killed. You may have heard tragic stories of babies left in dumpsters or public bathrooms. The parents who committed these acts may have been under severe emotional distress. The mothers may have hidden their pregnancies, fearful of what would happen if their families found out. Because they were afraid and had nowhere to turn for help, they abandoned their infants. Abandoning a baby puts the child in extreme danger. It is also illegal. Too often, it results in the baby's death. Because of the Safely Surrendered Baby Law, this tragedy doesn't ever have to happen in California again.

A baby's story

At 8:30 a.m. on Thursday, July 25, 2002, a healthy newborn baby was brought to St. Bernardine Medical Center in San Bernardino under the provisions of the California Safely Surrendered Baby Law. As the law states, the baby's mother did not have to identify herself. When the baby was brought to the emergency room, he was examined by a pediatrician, who determined that the baby was healthy and doing fine. He was placed with a loving family while the adoption process was started.

Every baby deserves a chance for a healthy life. If someone you know is considering abandoning a newborn, let her know there are other options.

It is best that women seek help to receive proper medical care and counseling while they are pregnant. But at the same time, we want to assure parents who choose not to keep their baby that they will not go to jail if they deliver their babies to safe hands in any Los Angeles County hospital ER or fire station.

Sin pena.
Sin culpa.
Sin peligro.

Los recién nacidos pueden ser entregados en forma segura en la sala de emergencia de cualquier hospital o en un cuartel de bomberos del Condado de Los Angeles.

En el Condado de Los Angeles:
1-877-BABY SAFE
1-877-222-9723
www.babysafela.org

Estado de California
Gray Davis, Gobernador

Agencia de Salud y Servicios Humanos
(Health and Human Services Agency)
Grantland Johnson, Secretario

Departamento de Servicios Sociales
(Department of Social Services)
Rita Saenz, Directora

Consejo de Supervisores del Condado de Los Angeles
Gloria Molina, Supervisora, Primer Distrito
Yvonne Brathwaite Burke, Supervisora, Segundo Distrito
Zev Yaroslavsky, Supervisor, Tercer Distrito
Don Knabe, Supervisor, Cuarto Distrito
Michael D. Antonovich, Supervisor, Quinto Distrito

Esta Iniciativa tambien esta apollada por First 5 LA y INFO LINE de Los Angeles.

¿Qué es la Ley de Entrega de Bebés Sin Peligro?

La Ley de Entrega de Bebés Sin Peligro de California permite a los padres entregar a su recién nacido confidencialmente. Siempre que el bebé no haya sufrido abuso ni negligencia, padres pueden entregar a su recién nacido sin temor a ser arrestados o procesados.

¿Cómo funciona?

El padre/madre con dificultades que no pueda o no quiera cuidar de su recién nacido puede entregarlo en forma legal, confidencial y segura, dentro de los tres días del nacimiento. El bebé debe ser entregado a un empleado de una sala de emergencias o de un cuartel de bomberos del Condado de Los Angeles. Siempre que el bebé no presente signos de abuso o negligencia, no será necesario suministrar nombres ni información alguna. Si el padre/madre cambia de opinión posteriormente y desea recuperar a su bebé, los trabajadores utilizarán brazaletes para poder vincularlos. El bebé llevará un brazalete y el padre/madre recibirá un brazalete igual.

¿Qué pasa si el padre/madre desea recuperar a su bebé?

Los padres que cambien de opinión pueden empezar el proceso de reclamar a su recién nacido dentro de los 14 días. Estos padres deberán llamar al Departamento de Servicios para Niños y Familias (Department of Children and Family Services) del Condado de Los Angeles, al 1-800-540-4000.

¿Sólo los padres podrán llevar al recién nacido?

En la mayoría de los casos, los padres son los que llevan al bebé. La ley permite que otras personas lleven al bebé si tienen la custodia legal del menor.

¿Los padres deben llamar antes de llevar al bebé?

No. El padre/madre puede llevar a su bebé en cualquier momento, las 24 horas del día, los 7 días de la semana, mientras que entregue a su bebé a un empleado del hospital o de un cuartel de bomberos.

¿Es necesario que el padre/madre diga algo a las personas que reciben al bebé?

No. Sin embargo, el personal del hospital le pedirá que llene un cuestionario con la finalidad de recabar antecedentes médicos importantes, que resultan de gran utilidad para los cuidados que recibirá el bebé. Es recomendado llenar este cuestionario, pero no es obligatorio hacerlo.

¿Qué ocurrirá con el bebé?

El bebé será examinado y, de ser necesario, recibirá tratamiento médico. Luego el bebé se entregará a un hogar preadoptivo.

¿Qué pasará con el padre/madre?

Una vez que los padres hayan entregado a su bebé en forma segura, serán libres de irse.

¿Por qué California hace esto?

La finalidad de la Ley de Entrega de Bebés Sin Peligro es proteger a los bebés del abandono por parte de sus padres y de la posibilidad de que mueran o sufran daños. Usted probablemente haya escuchado historias trágicas sobre bebés abandonados en basureros o en baños públicos. Es posible que los padres que cometieron estos actos hayan estado atravesando dificultades emocionales graves. Las madres pueden haber ocultado su embarazo, por temor a lo que pasaría si sus familias se enteraran. Abandonaron a sus recién nacidos porque tenían miedo y no tenían adonde recurrir para obtener ayuda. El abandono de un recién nacido lo pone en una situación de peligro extremo. Además es ilegal. Muy a menudo el abandono provoca la muerte del bebé. Ahora, gracias a la Ley de Entrega de Bebés Sin Peligro, esta tragedia ya no debe suceder nunca más en California.

Historia de un bebé

A las 8:30 a.m. del jueves 25 de julio de 2002, se entregó un bebé recién nacido saludable en el St. Bernardine Medical Center en San Bernardino, en virtud de las disposiciones de la Ley de Entrega de Bebés Sin Peligro. Como lo establece la ley, la madre del bebé no se tuvo que identificar. Cuando el bebé llegó a la sala de emergencias, un pediatra lo revisó y determinó que el bebé estaba saludable y no tenía problemas. El bebé fue ubicado con una buena familia, mientras se iniciaban los trámites de adopción.

Cada recién nacido merece una oportunidad de tener una vida saludable. Si alguien que usted conoce está pensando en abandonar a un recién nacido, infórmele qué otras opciones tiene.

Es mejor que las mujeres busquen ayuda para recibir atención médica y asesoramiento adecuado durante el embarazo. Pero al mismo tiempo, queremos asegurarles a los padres que optan por no quedarse con su bebé que no irán a la cárcel si dejan a sus bebés en buenas manos en cualquier sala de emergencia de un hospital o en un cuartel de bomberos del Condado de Los Angeles.

EXHIBIT H

CHARITABLE CONTRIBUTIONS CERTIFICATION

Company Name

Address

Internal Revenue Service Employer Identification Number

California Registry of Charitable Trusts "CT" number (if applicable)

The Nonprofit Integrity Act (SB 1262, Chapter 919) added requirements to California's Supervision of Trustees and Fundraisers for Charitable Purposes Act which regulates those receiving and raising charitable contributions.

Check the Certification below that is applicable to your company.

☐ Bidder or Contractor has examined its activities and determined that it does not now receive or raise charitable contributions regulated under California's Supervision of Trustees and Fundraisers for Charitable Purposes Act. If Bidder engages in activities subjecting it to those laws during the term of a County contract, it will timely comply with them and provide County a copy of its initial registration with the California State Attorney General's Registry of Charitable Trusts when filed.

OR

☐ Bidder or Contractor is registered with the California Registry of Charitable Trusts under the CT number listed above and is in compliance with its registration and reporting requirements under California law. Attached is a copy of its most recent filing with the Registry of Charitable Trusts as required by Title 11 California Code of Regulations, sections 300-301 and Government Code sections 12585-12586.

Signature

Date

Name and Title of Signer (please print)